Care Quality Commission

Wirral University Teaching Hospital NHS Foundation Trust

Arrowe Park 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	Requires improvement
Medical care	Requires improvement
Surgery	Good
Critical care	Requires improvement
Maternity and gynaecology	Requires improvement
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Arrowe Park Hospital is one of two hospital sites managed by Wirral University Teaching Hospitals NHS Foundation Trust. The hospital is the main site and provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people's services, maternity and gynaecology services and a range of outpatient and diagnostic imaging services.

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

Wirral University Teaching Hospitals NHS Foundation Trust became a Foundation Trust on 1 July 2007. The trust provides services for around 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West footprint with 855 beds trust-wide, including 749 at Arrowe Park Hospital.

We previously inspected this hospital in May 2015 as part of a responsive unannounced inspection and found that there were shortages of nursing staff on some medical wards which we told the trust to address.

We carried out an announced inspection of Arrowe Park Hospital on 16 – 18 September 2015 as part of our comprehensive inspection of Wirral University Teaching Hospitals NHS Foundation Trust and we checked to make sure staffing levels had improved.

Overall, we rated Arrowe Park Hospital as 'Requires Improvement'. We have judged the hospital as 'good' for caring. We found that services were provided by dedicated, caring staff and patients were treated with dignity and respect. However, improvements were needed to ensure that services were safe, effective, well led and responsive to people's needs.

Our key findings were as follows:

Cleanliness and infection control

- The trust had infection prevention and control policies in place which were accessible to staff.
- Staff generally followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures. However, in the critical care unit not all staff followed 'bare below the elbows' guidance and there was mixed levels of compliance with hand hygiene protocols.
- 'I am clean' stickers were used to inform staff at a glance that equipment or furniture had been cleaned and was ready for use.
- There had been no cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia infections or clostridium difficile infections identified in surgical services across the trust between March 2015 and August 2015. However, across the same period, medical care services reported 21 cases of clostridium difficile infections, two cases of MRSA and six cases of MSSA. The data could not be split so as to separate cases that specifically occurred at Arrowe Park Hospital.
- According to the submitted and verified intensive care national audit and research centre data (ICNARC), the critical care unit performed as well and sometimes better than similar units for unit acquired MRSA and clostridium difficile infection rates.
- Side rooms were used where possible as isolation rooms for patients at increased risk of cross infection. There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room.
- We observed that the disposal of sharps, such as needle sticks followed good practice guidance. Sharps containers were dated and signed upon assembling them and the temporary closure was used when sharps containers were not in use.

Summary of findings

- Patient-led assessments of the care environment (PLACE) audits for 2013 and 2014 scored higher than the national average for cleanliness across the trust, specific data for Arrowe Park Hospital was not available.

Nurse staffing

- We previously inspected this hospital in May 2015 as part of a responsive unannounced inspection and found that there were shortages of nursing staff on some medical wards which we told the trust to address.
- The trust had responded positively to our last inspection and had actively recruited nursing staff in a variety of ways to improve staffing levels. However, there were still staffing shortfalls across the hospital.
- To attempt to address shortfalls in staffing, matrons met each day to discuss nurse staffing levels across the divisions to ensure that there was good allocation of staff and skills were appropriately deployed and shared across all wards. In July 2015 there were still 70 nursing vacancies in medical and acute services across the trust.
- The trust had a high vacancy rate for nursing staff in medical services trust wide, which was 13% at the time of the inspection. The turnover of nursing staff was 9.7%.
- The vacancy rate for nurses in surgical services was below 3% for the five month period prior to the inspection. At the time of the inspection the vacancy rate for nurses across surgical services trust-wide was 2.4%.
- There was no recognised acuity tool in use to determine staffing numbers on paediatric wards. A band 6 nurse devised the staff rota and the skill mix of each shift was based on their knowledge of individual staff competencies.
- The staffing and skill mix on surgical ward areas and in theatre areas was sufficient, with some periods of reduced staffing in areas because of last minute sickness and unexpected events. However, there was a lack of surgical staff trained in paediatric life support. This training was not mandatory for staff, despite them regularly working with children.

Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- The information we reviewed showed that medical staffing was generally sufficient at the time of the inspection.
- The trust had identified areas, such as the emergency department and medical specialties, where medical staff shortages presented a risk to patient care and treatment and were working hard to recruit and retain consultants.
- The vacancy rate for medical staff was 12.4% and the turnover of medical staff in medical services trust wide was 18% at the time of the inspection.
- The total number of shifts covered by locum medical staff in medical services trust wide, between April 2015 and September 2015, was 1,428. This was for a number of reasons including vacancies, extra staffing over and above the normal levels and extra ward rounds. Locums were either trust staff working extra shifts or from an agency.
- The number of palliative care consultants was below the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance.
- There were 57.4 whole time equivalent (WTE) vacancies across all staffing in the diagnostics and imaging services as of August 2015.

Mortality rates

- Monthly governance meetings were in place where mortality, incidents and actions were discussed. Information was then cascaded to senior staff via email to enable sharing with other staff. However, in medical services it was unclear if any actions for improvement were agreed at the meeting.
- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at

the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to England. A score of over 100 means more adverse (worse) outcomes than expected and a score of less than 100 means less adverse (better) outcomes than expected. Between October 2013 and September 2014 the trust score was 97.

Nutrition and hydration

- The majority of patients we spoke with said they were happy with the standard and choice of food available.
- In the CQC accident and emergency patient survey 2014, patients gave the emergency department a score of seven out of ten for being able to access suitable food or drink whilst in the department.
- Staff in surgical services managed the nutrition and hydration needs of patient's well, both pre and post operatively. Patients were given information in the form of leaflets about their surgery and told how long they would need to fast pre-operatively.
- In all the records we reviewed, a nutritional risk assessment had been completed and updated regularly. This helped identify patients at risk of malnutrition and adapt to any ongoing nutritional or hydration needs.
- A coloured tray system was in place to highlight which patients needed assistance with eating and drinking. The trust had an internal target to ensure that 75% of patients got assistance with eating when they required it. Information provided by the trust showed that they were not meeting this target in medical specialties.
- Staff consistently completed charts used to record patients' fluid input and output and where appropriate staff escalated any concerns.
- The trust was awarded UNICEF baby friendly accreditation in July 2014 for work related to supporting breastfeeding and parent infant relationships.

We saw areas of outstanding practice including:

- Senior clinicians on the emergency surgical assessment unit had recognised that fluid balance monitoring could be improved and introduced a training programme for health care support workers to achieve this aim. Health care support workers told us they felt empowered by the training and saw fluid balance monitoring as an integral part of their role after it. Audits showed that the completion of fluid balance charts had improved since the training and senior clinicians reported that there had been a significant reduction in the number of patients developing acute kidney injuries (a condition associated with dehydration).
- The sentinel stroke national audit programme (SSNAP) latest audit results rated the trust overall as a grade 'A' which was an improvement from the previous audit results when the trust was rated as a grade 'B'. Since October 2014 the trust had either been ranked first or second regionally in the SSNAP audit.

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

Importantly, the hospital must:

Urgent and emergency care

- Ensure call bells are available in every bay and placed with patients.
- Staffing continues to remain a focus and that shifts are adequately staffed to meet the needs of patients.
- Ensure that risks are always managed and mitigated in a timely way.

Medical care (including older people's care)

- The trust must ensure that robust information is collected and analysed to support improvements in clinical and operational practice.
- The trust must ensure that care and treatment is only provided with the consent of the relevant person and if a patient lacks capacity to consent, the Mental Capacity Act (2005) principles are adhered to. This must be supported by staff receiving training in consent and the principles of the 2005 act.

Summary of findings

- The trust must deploy sufficient staff with the appropriate skills on wards, especially on the medical short stay ward and on ward 16 at night.
- The trust must ensure that learning is shared across all service areas and the reasons for any changes made clear to all staff.
- The trust must ensure that records are kept secure at all times so that they are only accessed and amended by authorised people.

Surgery

- The trust must ensure that there are adequate numbers of suitably qualified staff in theatre recovery areas to ensure safe patient care.
- The trust must ensure that all staff involved with the care and treatment of children receive adequate life support training.
- The trust must ensure that all staff receive are appropriately trained and able to use the incident reporting system.

Critical care

- The trust must address the governance shortfalls in critical care and make sure that the systems and processes in place for assessing, monitoring and mitigating local risk are managed effectively.
- The trust must ensure that all staff understand the thresholds for reporting incidents and are encouraged to use the electronic reporting system.
- The trust must make sure that all staff understand and comply with the best practice in infection prevention and control. This includes appropriate use of handwashing and the use of antiseptic hand gels.

Maternity and gynaecology

- Review the management of the electronic rostering system to ensure it does not allow staff to be rostered on different wards at the same time.
- The provider must deploy sufficient clinical and midwifery staff with the appropriate skills at all times of the day and night to meet the needs of women following the trust risk assessment and escalation procedures.
- The provider must ensure that there is a detailed overview of the types and seriousness of incidents and learning is shared across all service areas and the reasons for any changes made clear to all staff.
- The provider must make sure individual care records are always accurate and completed contemporaneously.
- The provider must make sure community midwives have easy access to the emergency medication and equipment detailed in best practice guidance. The equipment must be checked and items provided within the use by date.

Children and young people's services

- Resuscitation trolleys must be appropriately checked and the log book must be signed to confirm all items are in working order. The trolley must include a defibrillator at all times.
- Must ensure that there is a robust system to determine staffing numbers which takes into account the acuity of patients and skill mix of staff.
- Information must be collected and analysed to support developments in clinical and operational practice.
- Must review the children's safeguarding training to ensure it meets Royal College of Paediatrics and Child Health (RCPCH) guidelines 2014.

End of life

- Ensure that any complaint received is investigated and necessary and proportionate action is taken in response to any failures identified by the complaint or investigation.
- Seek and act on feedback from relevant persons and staff teams, for the purpose of continually evaluating and improving services.

Summary of findings

- Evaluate and improve their practice in respect of the processing of information relating to the quality of people's experience.
- Ensure there is a robust vision and strategy for end of life services and all staff are aware of them.
- Ensure that there is an appropriate replacement care plan in place across the trust following the withdrawal of the Liverpool Care Pathway.
- Ensure that all risks associated with end of life services are recorded and monitored with appropriate actions taken to mitigate them.

Outpatients and diagnostics

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

In addition the trust should:

Urgent and emergency care

- Review and introduce regular audits of patient records to ensure all relevant details are correctly sourced and recorded.
- Review and evaluate the outcomes from use of the potential sepsis warning tool.
- Take action to address waiting times and the access and flow through the hospital.

Medical care (including older people's care)

- The trust should ensure that hazardous chemicals are stored appropriately in a locked cupboard when not in use.
- The trust should ensure that the acuity of patients on the coronary care unit is regularly assessed to ensure there is an appropriate skill mix of staff.
- The trust should ensure that trolleys used to store records and sharp instruments are kept secure when not being used.
- The trust should ensure those patients are discharged as soon as they are fit to do so.
- The trust should ensure that patients are not moved ward more than is necessary during their admission and are cared for on a ward suited to meet their needs.
- The trust should ensure that patients' views are sought to help inform changes to services provided.
- The trust should ensure that actions to improve standards of medicines management are identified in a timely way.
- The trust must consider implementing formal procedures for the supervision of staff to enable them to carry out the duties they are employed to perform.

Surgery

- The trust should ensure that the emergency surgical assessment unit is not used for medical outliers.
- The trust should ensure that patients are not kept in theatre recovery areas for long periods of time or overnight.

Critical care

- The trust should ensure that all equipment is regularly serviced, maintained and remains fit for purpose.
- The trust should ensure that all patient records are accurate and fit for purpose.
- The trust should ensure that any delayed discharges from critical care do not result in a breach of the government's single sex standard.
- The trust should consider developing to plans to indicate when facilities will be upgraded to comply with the current HBN 04-02. It is imperative that critical care is delivered in facilities designed for that purpose.
- The trust should consider how it is going to improve performance in reducing the number of delayed and out of hours discharges of patients from critical care.

Summary of findings

- The trust should consider articulating a vision and strategy for the critical care service and communicating this to its staff.

Maternity and gynaecology

- The provider should ensure women and babies who are subject to safeguarding or child protection concerns have their needs reviewed before they are discharged from the maternity service.
- The provider should consider making it possible for all staff to be able to complete incidents directly onto the system
- The provider should make sure the arrangements for managing medicines and medical gases keep people safe and meet the relevant best practice guidance.
- The provider should ensure the general public are given opportunities to comment on their strategic plans.
- The provider should consider providing written information in different languages.
- The provider should consider maternity and gynaecology working more closely together so that effective systems can be shared.
- The provider should consider ways of improving staff satisfaction with working for maternity services at Arrowe Park Hospital.

Children and young people's services

- The patient electronic system in the emergency department should include a safeguarding identifier to inform staff of known safeguarding concerns.
- The trust should consider adding a paediatric nurse to the trust wide safeguarding team.
- A robust development plan should be in place to improve staff skills.
- The cot space on the neonatal ward should meet British Association of Perinatal Medicine (BAPM) standards.
- There should be more integrated working between the wards and the children's assessment unit.
- All equipment in all areas of the children ward, neonatal unit and the children's assessment unit should be tested for electrical safety and all plug sockets should have safety plugs.
- There should be an active board level representative for children and young people's services.

End of life

- Ensure policies and protocols are reviewed and monitored regularly to ensure their effectiveness and implementation is consistent across the trust.

Outpatients and diagnostics

- The trust should take steps to ensure that equipment is available and fit for use with minimal disruption to the service.
- The trust should ensure that medication is not left unattended when not in use.

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	Requires improvement 	Between December 2014 and April 2015 the emergency department consistently failed to meet the national target to see, treat and discharge 95% of patients within four hours. The number of patients who waited between 4 and 12 hours to be admitted to wards was also consistently higher than the national average. The trust had worked to accurately calculate the right number of staff required to care for patients. However, staff rotas showed that there were often lower than the required levels of nursing and medical staff on duty. Awareness about quality measurement within the department was limited. Actions to manage and mitigate risks were not always undertaken in a timely way. Patients were happy with the care provided and said staff were pleasant. However, call bells were not accessible to patients across the department. Staff were below the trust target of 95% for mandatory training and only 50% of medical and nursing staff had completed safeguarding training to the required standard. The trust had responded positively to concerns in relation to the identification and management of sepsis by implementing a sepsis pathway and an electronic tool to support the recognition of potential sepsis and prompt early intervention. Policies and procedures were evidence based and developed in line with national guidance from professional bodies such as the Royal College of Emergency Medicine. Multi-disciplinary working was evident within the department, trust and wider community. Staff told us that the emergency department (ED) had developed an open and honest culture and excellent teamwork. There was a shared vision for the future of patient care.
Medical care	Requires improvement 	We previously inspected this hospital in May 2015 and found that there were shortages of nursing staff on some medical wards. Staffing levels had improved since the last inspection but there were concerns in relation to nurse staffing on some of the wards at night and the medical short stay ward. Incidents were reported by staff but the reasons

why changes had been made were not always communicated to all staff. Clinical staff had access to information they required, however, when agency staff were used, they were not always able to access the required information. Records trolleys were left unlocked on some of the wards we visited. Best practice guidance in relation to care and treatment was usually followed. Low numbers of staff had received level two and three mental capacity act training which led to some uncertainties about practice amongst staff. A large number of patients were being cared for in non-speciality beds. Some patients had to stay in hospital longer than was needed due to care packages not being in place when they were ready for discharge. Patients received compassionate care and their privacy and dignity was maintained, although there was limited interaction with patients on ward 24. Where possible, patients were involved in their care and treatment and could access emotional support if they needed to. There were governance structures in place. However, some risks were not managed in a timely way. We saw limited evidence that information was collected and analysed to support clinical and operational decisions. The majority of staff said they felt supported and said that morale in medical services had improved over the past six months.

Surgery

Good

Care and treatment was provided in line with national and best practice guidance. The auditing of care and treatment was undertaken on regular basis. Patients received care and treatment from competent staff who worked well as part of a multidisciplinary team. Most patients had a positive outcome as a result of being treated within the service. Patients were treated with kindness, dignity, compassion and their relatives were involved in their care and treatment. There were low rates of avoidable harm including infections and pressure ulcers. Records were completed correctly and legibly and the majority of staff were up to date with their mandatory training. Medicines were well managed and appropriately stored. Patient records were clear, legible and up to date. The environment and equipment were generally visibly clean and well maintained. The service

Summary of findings

managed complaints well and we saw evidence that learning from complaints took place. Staff were aware of the trust's vision. Managers and leaders were visible and known to staff. There was evidence that the service strived to continually improve through public and staff engagement. Staff did not always report incidents because of a lack of training on how to use the system. When incidents were reported, feedback was not consistently given. Nurse staffing levels were sufficient on the surgical wards and in theatre areas. However, nurse staffing levels within theatre recovery were insufficient at times. This impacted on anaesthetic staff who stayed to observe patients. In addition, we found that most staff had not undertaken paediatric life support training despite regularly caring for children. There were a number of shifts identified where there were no paediatric life support trained nurses on duty.

Critical care — **Requires improvement** 

There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients. However, we found examples of incidents that were not reported. The clinical areas did not meet national guidance. Monitoring equipment and ventilators needed to be replaced but there was no clear plan in place to ensure capital funding was available to facilitate this. Transfer equipment for critically ill adults did not meet the current Intensive Care Society standard. Hand hygiene best practice was not being followed by all staff. There was no clear, shared vision or strategy for the unit. There was a governance structure in place though at times it was unclear how risks were being, monitored, managed and reviewed. Patient outcomes were within the expected ranges when compared with similar critical care units nationally. We saw patients, their relatives and friends being treated with care, compassion, dignity and respect.

Maternity and gynaecology — **Requires improvement** 

Staffing arrangements did not always ensure there were enough skilled and knowledgeable midwives on duty. There was inconsistency in the reporting and review of serious incidents including root cause analysis which lacked robustness in its approach and actions. The record keeping systems did not guarantee that accurate and up-to-date information about patients would be readily

available. Patients received consultant and midwifery-led care depending on where they chose to have their babies, and received the support of specialist staff for advice and guidance. Patients were cared for with kindness, compassion and they were positive about the standard of care and treatment. Staff were supported to learn and develop. Only a minority of maternity and gynaecology staff felt there was effective communication between ward staff and senior managers. Best practice guidance in relation to care and treatment was followed and plans were in place to participate in national and local audits. However, many of the audits had been discussed but not commenced. Staff were not supported to be involved in the overall development of the service. There was limited involvement of stakeholders or the general public in the trusts long-term plans for the service. The management structure of the maternity services was relatively new and a system review was being completed. The gynaecology ward and clinics were well run by the gynaecology service and ward managers.

Services for children and young people

Requires improvement

The systems to devise staffing numbers on the paediatric ward were not robust. Staff knew how to report incidents but did not always know what constituted an incident. There were concerns about equipment on the paediatric ward as the resuscitation trolley was not locked and did not have a defibrillator on it. We found some controlled drugs which had expired. The safeguarding policy did not refer to current guidance. We identified gaps in safeguarding case notes such as incomplete MARS (Multi Agency Referral Service) forms. Hand hygiene was good, staff washed their hands between patients and used aprons to reduce the risk of infection spreading. The neonatal unit did not meet the British Association of Perinatal Medicine (BAPM) standards for cot space which sometimes impacted on the number of babies that could be admitted. The service participated in national and local audits and the results were within national averages. A transition policy wasn't in place for children with long term health needs and nursing staff were unclear how to initiate a child's transfer to adult services in line with

guidance. The community paediatric service consistently failed to meet national referral to treatment targets and the waiting list was lengthy with some children waiting up to 47 weeks. However, services for children at Arrowe Park Hospital consistently met the national referral to treatment targets. Parents and young people felt safe and informed about their treatment. We observed patients been looked after with respect and dignity. Training and development of staff on the paediatric ward was not a priority and staff told us they were not supported to develop themselves. Care on the neonatal unit was well managed and local leadership on the unit was clear and directive. The unit constantly looked at ways to improve care. There were governance structures in place. However, some risks on the register had been there since 2012 with actions still being completed.

End of life care

Requires improvement

There was an insufficient number of general nursing staff who had received appropriate training in end of life care. The palliative care consultant staffing levels across the trust were below the recommended guidelines. The trust performed worse than the England average in the National Care of the Dying Audit, published in May 2014. The trust's policy did not clearly specify in which cases staff were required to complete do not attempt cardio-pulmonary resuscitation (DNA CPR) forms or how long after a patients admission they had to complete them. When DNA CPR decisions were recorded, this information was not always readily available to staff if a patient re-presented at the hospital following their discharge. There was a draft three-year vision developed by the trust's end of life care committee. However, we found no evidence that this had been communicated to staff. There was no overarching monitoring of the quality of the service across the trust. Complaints were not always responded to appropriately. Interim guidance and a toolkit had been put in place following the removal of the Liverpool Care Pathway nationally in 2013. Whilst a replacement care plan had recently been agreed not all staff were aware of it and we did not see it being used. Specialist palliative care (SPC) nurses were able to describe safeguarding procedures and provided us

with examples of how these would be used. Staff were aware of how to report an incident or raise a concern. Appropriate equipment was available to patients at the end of their life and it was adequately maintained. Medicines were managed appropriately. Patients were involved in care planning and decision making. Staff were respectful and treated patients with compassion. Specialist palliative care team members were visible, competent, and knowledgeable. Staff within the SPC team were very motivated and committed to meeting patients' individual needs at the end of life and were actively developing their own systems and projects to help achieve this.

Outpatients and diagnostic imaging — **Requires improvement**

There were significant staff vacancies across the whole trust in diagnostic and imaging services. The service failed to meet the national target in July and August 2015 for referral to treatment times. In addition, the trust failed to meet their internal target for urgent reporting of plain x-rays between April 2015 and August 2015. The radiology department had equipment that exceeded the recommended ten year life span and regular equipment failures caused delays for patients. There were a large number of clinic appointments cancelled due to the process in place for rebooking appointments. Managers had plans to implement a partial booking system to reduce cancellation of appointments and to offer patients more choice. Some clinical governance measures were in place for radiology however, there had been no radiation safety committee meetings since September 2012. We saw that teams worked well locally but some staff were not formally made aware of key issues following complaints, incidents and audits. Staff felt supported by their local managers however Patients were treated in a dignified and respectful way by caring and committed staff. There was a clear process for reporting and investigating incidents and staff received feedback. Records were available for 99% of outpatient appointments. Mandatory Training was well attended and staff were aware of their role and responsibilities in relation to safeguarding. The leadership and governance arrangements did not always support the delivery of high quality care. Staff shortages had

Summary of findings

	been identified and placed on the risk register. However, progress was slow to resolve the issue. Cleanliness and hygiene was of a good standard throughout areas we visited and staff followed good practice guidance in relation to the control and prevention of infection.

Arrowe Park 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

Detailed findings

Contents

Background to Arrowe Park Hospital

Arrowe Park Hospital is one of two hospital sites managed by Wirral University Teaching Hospitals NHS Foundation Trust. The hospital is the main site and provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people's services, maternity and gynaecology services and a range of outpatient and diagnostic imaging services.

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

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

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

Our inspection team

Our inspection team was led by:

Chair: Jenny Leggott

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included two CQC inspection managers, 11 CQC inspectors, a senior analyst and a variety of specialists including: a director of nursing, a deputy medical director, a pharmacist, two emergency nurses, two medical care nurses, a consultant surgeon, an intensive care consultant, a consultant obstetrician, a risk and governance midwife, an independent safeguarding children consultant, a consultant paediatrician, a nurse specialist for children and young people, a director for palliative care hospice, a palliative care nurse, a critical care nurse, a consultant haematologist a renal histopathologist, a senior nurse for theatres and day care, a ward manager, a senior lecturer in radiography, a junior doctor and a student nurse. We also used two experts by experience who had experience of using healthcare services.

Detailed findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

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

The announced inspection of Arrowe Park Hospital took place on 16 – 18 September 2015. The inspection team inspected the following core services:

- Urgent and Emergency Services
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and gynaecology
- Children and young people's services
- Outpatients and Diagnostic Imaging
- End of life care

As part of the inspection, we held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, 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 undertook an unannounced inspection between 6pm and 9pm on 24 September 2015 at Arrowe Park Hospital. As part of the unannounced inspection, we looked at the emergency department and medical care wards.

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

Facts and data about Arrowe Park Hospital

Arrowe Park Hospital is one of two hospital sites managed by Wirral University Teaching Hospitals NHS Foundation Trust. Arrowe Park is the main site. There are 855 beds across the trust in total, with 749 at Arrowe Park Hospital.

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

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

In 2014/15 there were 89,277 emergency department attendances, 54,737 emergency admissions, 41,693 elective day case admissions across the trust, 111,874 new outpatient attendances and 338,834 diagnostic examinations. The trust employs 4,782 members of staff.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

Wirral University Teaching Hospitals NHS Foundation Trust provides urgent & emergency services for 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West area.

The service consists of an emergency department (ED) and children's emergency department (CED). Both are based at Arrowe Park Hospital. The ED operates 24 hours a day, seven days a week. The CED is open between 9am and 11pm Monday to Thursday, and between 10am and midnight from Friday to Sunday, catering for children and young people up to the age of 16.

Between April 2014 and April 2015 the ED saw 89,277 patients with an average attendance of 244 adults and 60 children per day.

The ED is a designated trauma unit, providing care for trauma patients. However, the most severely injured trauma patients are taken to the nearest major trauma centre in Liverpool if their condition allows direct transportation. If not, they are stabilised at Arrowe Park Hospital and treated or transferred as required.

There are two main waiting areas: one for patients with minor illness or injury (with a separate area for children which is available when the CED is open) and another for patients brought in via ambulance. There are seven bays for initial assessment and triage.

Following initial assessment and triage, patients receive care and treatment in four main areas: the 'see and treat', 'trolleys', 'majors high dependency (HD)' and resuscitation areas.

Patients with minor injuries are directed to one of four 'see and treat' cubicles. Those with more serious illness or injury are seen in the 'trolleys' or 'resuscitation' areas. The trolleys area has 13 bays and the resuscitation area has eight bays including a paediatric and a trauma bay. The 'majors HD' area is supplementary. With four bays and two side rooms, this area is used when patient numbers are high, as a 'step down' from the resuscitation area depending upon staffing levels.

The service also has an emergency department review unit (EDRU) with 11 beds, primarily to be used for patients requiring observation following attendance to the ED.

In the CED there are five cubicles, a treatment room and a room dedicated to adolescents. When the department is closed, children and young people are assessed and treated in the main ED.

Additionally, there are two relatives' rooms and a bereavement room for people to spend time with a loved one who has passed away.

During the inspection we spoke with 15 patients, 54 staff including nurses, doctors, managers and support staff. We observed daily practice and reviewed 23 patient records. Prior to and following our inspection we reviewed further information about the service as well as reviewing information supplied by the trust.

Urgent and emergency services

Summary of findings

Between December 2014 and April 2015 the emergency department (ED) consistently failed to meet the target to see, treat and discharge 95% of patients within four hours. The number of patients who waited between 4 and 12 hours to be admitted to wards was also consistently higher than the national average during this time.

The trust had worked to accurately calculate the right number of staff required to care for patients. However, staff rotas showed that there were often lower than required levels of nursing and medical staff on duty.

Awareness about quality measurement within the department was limited. Staff were not aware of any regular robust quality measures used to improve outcomes but they did have knowledge of national targets.

A risk register was in place and was monitored, but actions to manage and mitigate these risks were not always undertaken in a timely way. For example, we saw that the need for an audit was identified in January 2014 but this hadn't been completed at the time of the inspection, over 18 months later.

Patients were happy with the care provided and said staff were pleasant. Patients and their relatives were aware of care plans and provided with food. However, call bells were not accessible to patients across the department. We saw evidence that suggested capacity assessments and consent were not always documented in patient records.

The appraisal rate for medical and nursing staff was above the trust's target of 88% but below target for all other staff such as clinical support staff. Staff were below the trust target of 95% for mandatory training and only 50% of medical and nursing staff had completed safeguarding training to the required standard.

Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the Royal College of Emergency Medicine.

The trust had responded positively to concerns in relation to the identification and management of sepsis by implementing a sepsis pathway and an electronic tool to support the recognition of potential sepsis and prompt early intervention.

Multi-disciplinary working was evident within the department, trust and wider community. Staff told us that the ED had developed an open and honest culture and excellent teamwork. There was a shared vision for the future of patient care.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

Whilst the areas we inspected were visibly clean, equipment and storage trolleys were not. We saw stains, dust and dirt present in these areas. Equipment records showed that daily checks were not always completed. Patient records were not always fully completed and the numbers of staff up to date with mandatory training did not meet the trust's target.

The trust had worked to accurately calculate the right number of staff required to care for patients. However, staff rotas showed that in practice there were often lower than the identified levels of nursing and medical staff on duty.

Staff knew how to report incidents and did so when required. Hand hygiene practice was adopted by staff. Areas of the department had been refurbished to be bright and visibly clean and plans were in place to continue this refurbishment to all areas. Medicines and equipment were accessible and stored in a safe way. Systems were in place to protect patients from abuse and child attendance monitored. There were plans and staff were trained to deal with major incidents.

Incidents

- There was a culture of reporting and learning from incidents amongst staff.
- Staff were encouraged to report incidents and told us they knew which incidents to report and how to do this. Staff had access to a 'hotline' for advice about serious incidents if required.
- Incidents were reported using an electronic system. Staff received emails confirming receipt of an incident. Following investigation, feedback was provided via email, and learning was shared in staff bulletins, meetings or training.
- Despite this, a senior staff member told us that once an incident was logged onto the system, it took too long to process before feedback could be provided for staff. Whilst incidents were briefly reviewed to ensure immediate or serious issues were identified, there was a back log of less serious incidents which required processing, which delayed staff receiving feedback. To address this, extra senior staff had completed training to process these incidents.
- Five serious incidents were reported between May 2014 and June 2015. Three of these related to a delay in diagnosis. The other two related to actions taken to safeguard patients. We saw evidence that serious incidents were investigated using a root cause analysis process, and actions identified to prevent recurrence.
- A further serious incident took place in July 2015 which related to a medication error. The investigation into the root cause of this incident was still being investigated at the time of the inspection. The trust took a number of immediate remedial actions at the time of the incident and had developed an overall action plan, which was still in progress at the time of the inspection.
- Mortality and morbidity was discussed at monthly governance meetings attended by consultants and nurses.
- Staff were not aware of Duty of Candour legislation. This is a legal requirement to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Out of eight staff including a consultant, junior doctors and staff nurses, only the consultant was able to tell us what this meant. However, staff were open in their approach to patients when errors were made.

Cleanliness, infection control and hygiene

- The departments were visibly clean and tidy but some equipment was not. For example, in the 'majors' area we found six equipment trolleys which were visibly dirty with dried blood-like stains on drawer handles and sides. A machine for taking clinical observations had dust and dirt around the base. However, when we revisited this area the following day we saw that the equipment had been cleaned.
- We saw some equipment such as mattresses being cleaned in the 'trolleys' and 'majors HD' areas of the emergency department (ED) and toys being cleaned in the children's emergency department (CED).
- Cleaning staff explained that toys were steam cleaned at least once weekly and wiped every day. There were no records to show this was being done, however nursing staff corroborated what we were told.

- Hand gel was available in all areas including main reception, entry and exit points and in individual cubicles.
- We observed nurses and doctors using hand gel and washing their hands between patients. Hand hygiene audits were completed based on the World Health Organization's 'five moments of hand hygiene' which describes the key points at which hand hygiene should be observed by healthcare staff. The results of audits undertaken in the service supported our finding that hand hygiene practice was good with 100% weekly compliance between April and September 2015.
- Information about infection rates in the departments was not displayed anywhere except the emergency department review unit (EDRU). In this unit, the September 2015 audit result was displayed and showed 92% compliance with infection prevention and control practice.
- Special measures were in place for patients attending the ED with symptoms of Ebola. Reception staff checked whether patients had travelled recently when they presented in ED and knew what action to take if Ebola was suspected. There was a room available for people suspected of having Ebola to be cared for in isolation.

Environment and equipment

- Following refurbishment in 2010 the main waiting, assessment, minor injury and resuscitation areas were light and spacious. A further phase of refurbishments was planned for the other areas but a date had not yet been announced.
- There was adequate seating in the waiting area, as well as clear signage explaining the process of attendance for visitors.
- The doorways which led to the CED assessment areas were accessible to the general public. This meant that people could enter the areas where children were being cared for without the knowledge of staff.
- Resuscitation equipment in the 'hub' was accessible to the general public but a checklist for reviewing the contents daily was present and up to date.
- Equipment such as mattresses were checked to ensure they remained waterproof and were not stained. We reviewed the checklists for mattresses in the EDRU. The records showed that checks were required on a daily basis but records indicated that checks weren't always completed.
- Equipment such as syringes, oxygen masks and tracheal tubes were stored in one room which was organised and tidy with clear labelling. There was a folder with a list of contacts and information about recent stock orders.
- Special 'kits' were available in the resuscitation area which contained equipment enabling staff to give specialist care more efficiently to patients with sepsis, or those who required chest drains or arterial lines. We also found that equipment for managing patients with a difficult airway was stored and organised in a particular order to simplify processes and limit the risk of choosing incorrect equipment in a time critical situation.
- Medicines requiring storage at low temperature were kept in fridges. The fridge temperatures were found to be correct and records indicated that temperature ranges were checked regularly.
- Portable appliance tests for electrical items were reviewed in the CED and were up to date.
- There was a designated area within the CED for adolescents where they could listen to music and watch DVD's. However, the DVD player was not working at the time we visited.

Medicines

- We reviewed incidents recorded by the department between February 2015 and July 2015 and found 30 incidents relating to medication issues such as incorrect storage, incorrect administration, and wrong labelling of medication. During our inspection we looked at how drugs were stored, checked and restocked.
- Storage of medicines in all areas was organised and tidy.
- Controlled medicines such as morphine were stored securely with keys held by designated staff.
- Medicines which required refrigeration were securely stored in locked refrigerators, or in specific circumstances, according to local risk assessments. The medicines we checked were within their expiry date.
- Pharmacy staff restocked medicines three times a week or on request.
- Records indicated that drugs were checked and signed appropriately in most areas on a daily basis to ensure none were missing or out of date. However, paediatric drug checks in the 'trolleys' area and in the resuscitation room in the CED had gaps in the record of daily checks. For example the week prior to the inspection, entries were missing on three days out of seven.
- Some patient group directive (PGD) medicines were held in the departments. PGD's are written instructions

which allow specified healthcare professionals to supply or administer particular medicines when prescriptions are not available. We checked a sample of these and found that they were up to date and authorised appropriately.

Records

- The service used an electronic patient record system. Some information (such as up to date clinical observations) was stored on it but paper records were used as well. These contained initial observations and hand written notes.
- When we asked for the results of any record audits, the trust advised these were not yet available. They explained that audits were suspended following the roll out of the new IT system and that they had only recently been re-introduced.
- We checked our own sample of 23 patient records during the inspection. Following review of the records, we found that 19 were not fully completed. For example, pain scores were missing in six records, initial observations were missing in three records and information relating to safeguarding and social circumstances was not recorded in five records. This led to a risk that information was not available to help staff provide the right care or treatment for patients.
- We checked a further five records of patients who were detained under the Mental Health Act and found that these were completed correctly. Staff used a flow chart and checklist process to ensure that these patients had been detained lawfully.
- For the most recent clinical observations staff accessed the electronic notes on the system from one of over 50 computer terminals because the paper notes did not contain this information. The terminals were available throughout the ED and staff reported no delays in accessing electronic records when necessary.
- Following initial assessment, some paper patient records were placed in an open tray in a corridor leading into the 'trolleys' area. This made them accessible to people walking through, including the general public.

Safeguarding

- The trust had a safeguarding policy and staff knew where to locate a copy if required. The policy covered a range of issues which included domestic and sexual abuse, female genital mutilation, radicalisation, forced marriage, sexual exploitation and honour based violence.
- Safeguarding information was displayed on noticeboards in the EDRU and the CED as a reminder to staff.
- Staff were familiar with issues requiring referral and the process.
- Staff in the ED showed us the electronic patient record system. They explained that staff completed fields during the triage process which ensured information to safeguard vulnerable people was captured. Once information was captured, a special icon was visible on the main screen. Staff could then access further details if required.
- The service had a dedicated safeguarding lead, based in the CED who was available during office hours. There was also a consultant safeguarding lead and a paediatric consultant who were available in the ED when on duty as well as on an on call basis.
- A manager told us that a safeguarding liaison nurse reviewed the records of all children who attended the CED to ensure any outstanding safeguarding issues were identified and sent to the central safeguarding team.
- The department was part of a local 'multi agency safeguarding hub'. These hubs are used nationwide and include professionals in children's care, police, health and education.
- Despite the processes in place, the trust confirmed that there had been no audits to assess the efficacy of safeguarding processes for vulnerable children or adults in the ED within the last year
- Staff completed one of three levels of safeguarding training dependent upon their role. All staff in regular contact with patients such as nurses should have completed level two training. Those who offered safeguarding advice to others such as lead consultants should have completed level three training. Figures provided by the trust showed that not enough staff were trained in these levels. For example, only 43% of medical staff and 50% of nursing staff were up to date with level two training. The trust target was 90%.

Mandatory training

- Staff received mandatory training on a rolling 18 month programme (block B) in areas such as infection control

and medicines management and a three year rolling programme (block A) in areas such as safeguarding, manual handling and fire. Staff were alerted that mandatory training was due via their manager. Further annual e-learning was also available.

- The trust's target was for 95% of staff to have completed mandatory training. At the time of our inspection, 97% of medical staff were up to date with three yearly training (block A) and 93% of nursing staff and 83% of other staff (such as clerical staff) were up to date.
- The target of 95% was not achieved in any staff group for the 18 month (block B) training. 80% of medical staff, 64% of nursing staff and 51% of other staff had completed it. This meant that some staff may not have the up to date skills required to fulfil their roles.

Assessing and responding to patient risk

- The service used different tools to triage patients and assess their clinical condition. These included the Manchester Triage System (MTS), a Modified Early Warning Score (MEWS) system and a sepsis indicator warning system.
- The MTS tool aims to reduce risk through triage, ensuring patients are seen in order of clinical priority and not in order of attendance. We saw evidence of MTS being used to triage patients.
- The MEWS system used clinical observations within set parameters to determine how unwell a patient may be. When a patient's clinical observations fell outside certain parameters they produced a higher score, which meant they required more urgent clinical care than others. A MEWS score was required as part of the patient's initial assessment, and at intervals for routine monitoring for example every two hours.
- We found that initial observations were not recorded in three patient records and staff responsible for taking these observations acknowledged that MEWS were not always monitored in a timely manner.
- Guidance issued by the Royal College of Emergency Medicine (April 2011) recommends that rapid initial assessment of patients who arrive by ambulance should take place within 15 minutes of arrival or registration. Between January 2014 and January 2015 the time taken to carry out a rapid assessment in the ED ranged from 11 and 18 minutes, which was consistently above (worse) the England average.
- The general time to treatment was consistently above (worse) the England average from January 2015 to January 2015 and from February 2014 – December 2014 it was generally higher (worse) than the national accepted standard of 60 minutes.
- Senior clinical advice was available at all times. Consultants were based in the department until at least midnight or available on an on call basis with the ability to attend within approximately 30 minutes if required. Middle grade doctors were available throughout the day and night.
- Reception staff explained that they mostly used experience and intuition to identify patients who might require immediate clinical intervention. The exception was that they asked all patients if they had travelled from abroad within the last 3 weeks to ensure potential viruses such as Ebola were efficiently identified. Whilst there was no other formal tool used, staff explained they mentored new staff for as long as required to enable them to identify patients requiring immediate intervention. We observed reception staff do this for a patient who came in having had a seizure that morning.
- The waiting area was not visible to staff. The risk that patients might worsen whilst out of sight was mitigated by checking the area at intervals throughout the day (we saw that five checks had been completed on 24 September) and there was also a button in the reception area for people to press should immediate assistance be required.
- An escalation process was in place for staff to implement if the department started to exceed capacity. This was based on a number of indicators such as the number of attendances in the last hour and the time taken to triage patients with minor injury or illness.

Nursing staffing

- The service assessed staffing requirements through the use of a 'Baseline Emergency Staffing Tool' (BEST). This recognised tool assesses nurse staffing requirements in emergency departments by analysing the volume and pattern of workload against staffing levels.
- Following use of the tool a few years ago, the service reassessed their requirements again in November 2014. This assessment identified that the staffing establishment needed to be increased in the

department, which created vacancies. The trust had worked to fill vacancies, recently recruiting ten nurses. A further four vacancies were being recruited to at the time of the inspection.

- In the meantime, staffing issues were addressed in a number of ways. Bank or agency staff were sourced, the shift coordinator undertook clinical duties, nurse practitioner duties were changed to accommodate ED requirements, or clinical support workers (CSWs) were used in place of registered nurses. However, CSWs cannot fulfil the full range of duties that a nurse can.
- The department was rarely staffed to their defined staffing establishment and senior managers acknowledged staffing was a challenge. During our inspection the department was understaffed by two nurses. On another occasion the resuscitation area was understaffed by one nurse. Upon further review we found shortfalls in nurse staffing on all but three dates in July 2015 and all but four dates in August 2015.
- Between March and July 2015, 12 incidents were reported which related to problems with nurse staffing in the ED. Nurses and CSWs said staffing was not as good as it should be. Medical staff said that nursing pressures caused workload to accumulate.
- Staff told us that the departments were often busy and staff struggled to cope with demand. One staff member described feeling that patients 'miss out' on care at these times.
- Daily meetings to try to manage staffing levels were attended by matrons, ward managers or deputy ward managers across the hospital. Here, shortfalls in staffing were discussed and patients ready for discharge were highlighted so that patient numbers did not rise unnecessarily.
- Following this meeting staffing numbers and any plans or identified actions were emailed to matrons and ward managers.
- Nursing staff sickness rates had reduced over the last 12 months from 12% to 3.6%.
- Staffing numbers were not displayed in the department for visitors.

Medical staffing

- The department employed eight consultant staff against an establishment of ten whole time equivalents (WTE). At the time, vacancies were filled by locum consultants who worked regularly in the ED. Consultants were available until at least midnight and they were available on call thereafter.
- We reviewed medical staffing rotas for August 2015 and found only one senior doctor on duty on 22 occasions between the hours of 9pm and 6am or 11pm and 8am. Whilst there were at least three junior doctors also on duty at these times, the registrar had to review all patients in the department (except minor injury patients), prior to admission, transfer or discharge. A senior nurse told us that having only one senior doctor had caused delays for some patients who were waiting for review.
- We observed handovers between staff on different shifts. The medical staff handover was conducted by a consultant in an organised way. Staff could raise issues or queries if required and patients were designated to individual staff members for care.
- Medical staff told us that staffing levels in general were a concern to them and limited their ability to see patients.

Major incident awareness and training

- The trust had a policy for use during major incidents as well as a business continuity plan to maintain core business when large scale incidents occurred.
- Key staff were designated as leads during major incidents.
- Clinical and clerical staff were aware of their roles and knew where to find equipment should a major incident be declared.
- We checked the storage area for major incident equipment which was tidy and organised with stock available and within date.
- Scenario based training took place and staff reported this had been completed within the last 12 months.
- Staff told us about a recent chemical incident which involved decontaminating patients. A debrief was scheduled but in the meantime staff reported that the process was clear and effective with only a minor issue for learning which related to signage.
- Plans were in place for winter which involved recruitment of extra staff, opening two additional wards, one in November and one in December 2015, securing available beds in the community and contingency plans were also in place should community beds be withdrawn.

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

Good

Care and treatment was delivered in line with evidence based guidelines and pathways were based on national standards.

The service had contributed to some national audits in 2013/2014, in areas such as asthma and sepsis which showed areas for improvement. Action plans had been completed in response to these and were in progress.

The trust had responded positively to concerns in relation to the identification and management of sepsis by implementing a sepsis pathway and an electronic tool to support the recognition of potential sepsis and prompt early intervention. Since their introduction, the trust had seen a positive increase in the identification and treatment of patients with sepsis.

Nursing and medical staff worked together and appeared competent in their contact with and treatment of patients. There was evidence of multi-disciplinary work with colleagues as well as with other agencies such as social services and the police.

Most staff felt supported by their managers. Nursing and medical staff were up to date with their appraisals; however other staff, such as clinical support workers, were not. Competency based learning was not fully implemented but was in progress.

Patients were offered pain relief appropriately but pain scores were not always recorded to support this.

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

Evidence-based care and treatment

- Pathways for managing patients were in place and based on up to date guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (CEM) clinical standards. The pathways covered conditions such as sepsis, stroke, atrial fibrillation (abnormal heart rhythm), gastro-intestinal problems and chest pain. Pathways were also in place for patients with alcohol problems, and those who required a treatment called primary percutaneous cardiac intervention (treatment for a specific type of heart attack).
- Concerns regarding sepsis were raised by HM Coroner in relation to a delay in the administration of antibiotics for a patient in September 2014. In response, the service implemented plans to improve sepsis care, which included introducing a sepsis care pathway and extra training for staff. In addition, the trust developed an electronic systemic inflammatory response syndrome (SIRS) tool. The tool worked as an adjunct to the clinical assessment to support the recognition of potential sepsis and prompt early intervention. It was developed using evidence based international standards. Following implementation of the action plan and introduction of the electronic SIRS tool, the trust reported a positive increase in the identification and treatment of patients with potential sepsis.
- The trust's stroke executive group met in June and September 2015 to share a range of updates including research, audit, and training
- Staff were not clear about the pathway for patients approaching the end of life. When we asked staff about this, they located a document detailing the Liverpool care pathway which was phased out of NHS practice in July 2014.
- The departmental risk register showed a number of risks recorded in July 2015 that compliance with NICE clinical guidelines would not be met. The risks applied to head injury, alcohol use disorders, transient loss of consciousness, anaphylaxis (severe allergic reaction) and headache. Actions to manage the risk were in progress and included auditing whether care and treatment of patients with these conditions was correct. However, in relation to transient loss of consciousness the risk register showed an audit had commenced in December 2014 but not yet been completed. Audits to assess anaphylaxis had been delayed. The risk register stated this was because the relevant patient records could not be identified until electronic prescribing was introduced to the emergency department (ED). The date for introducing this was not known.

Pain relief

- Patients told us that staff asked them about pain and offered pain relief when necessary.

- We reviewed 23 records and found that pain scores were not recorded in six of them. This included instances where strong pain relief was given to patients. This meant there was no recorded justification why controlled drugs such as morphine were administered to patients or how well pain was being managed.
- In the CQC Accident and Emergency (A and E) patient survey 2014 the trust scored six out of ten for patients not having to wait too long for pain relief, and seven and a half out of ten for patients feeling staff did all they could to help control pain in patients whilst in the ED.

Nutrition and hydration

- Vending machines dispensing hot and cold drinks and snacks were in the waiting area and bereavement room.
- Food and drinks for patients and those with them were available when appropriate. We saw toast, yoghurt and fruit juice being given to an ill child.
- In the CQC A and E patient survey 2014, patients gave the ED a score of seven out of ten for being able to access suitable food or drink whilst in the department.

Patient outcomes

- Unplanned re-attendance rates of patients within seven days had been audited for 2014. This showed that 6% of patients re-attend the ED after being discharged. The service performed better than all but one hospital in the surrounding area.
- The numbers of patients that waited longer than 4 hours to be seen, treated, transferred or discharged in the department ('breaches') was analysed daily. Figures were stored centrally including reasons for breaches. Senior nursing staff who worked in the department were aware of issues which included reduced medical cover, CT scanner issues and patients' needs being particularly high.
- The service was audited in two areas by the College of Emergency Medicine in 2013-2014. These were asthma in children, and severe sepsis and septic shock. Each audit reviewed 50 relevant cases.
- The asthma in children clinical audit identified areas for improvement. For example, staff did not meet the 15 minute time standard for completing initial observations or administer certain medicines. However, in response the trust produced plans to provide extra training which was in progress at the time of the inspection.
- The severe sepsis and septic shock clinical audit identified issues with the recording of vital signs with only 68% of these recorded within 15 minutes of arrival. Only 34% of patients had their blood glucose level recorded within 15 minutes of arrival and intravenous fluids were only administered in 84% of cases. The target for compliance in all these areas was 100%.
- Senior staff in the ED were unclear when asked about local audits (which measure the efficacy of care) and were not able to show us any evidence that these were done. The trust told us that audits were done locally to assess the care and treatment provided for patients with neutropenic sepsis, which showed that not enough patients were receiving antibiotics within the guideline target of 1 hour and an action plan to further educate clinical staff was created to improve this. Other audits were in progress at the time of our inspection, such as the efficacy of the chest pain pathway and management of patients with diabetic ketoacidosis.
- The trust did provide a copy of a general review of the ED from August 2015. The review used a small sample of data such as ten records, observational spot checks and a review of checklists. The findings were that whilst records were completed correctly, checklists for reviewing equipment were not. Findings also indicated that staff attitudes were caring and professional, but wristbands were not given to patients routinely. These points were noted as areas for improvement but we were not shown any action plans to improve practice.

Competent staff

- The trust target for 88% of staff to receive annual appraisals with their line manager was met for medical (97%) and nursing (90%) staff. However, only 56% of other staff (such as CSWs) received their annual appraisal.
- New starters worked on a supernumerary (surplus) basis for two weeks and underwent a preceptorship prior to becoming substantive members of staff. A competency framework booklet had recently been developed for new nurses to record their clinical practice. The booklet also acted as a revalidation record for staff already working as nurses within the department. This was due to be printed at the time of inspection. Prior to this staff said there was nothing formal in place in terms of competency assessments.

- Staff completed simulation (skills and drills) exercises which were organised informally. The last exercise involving resuscitation had been done approximately six months ago.
- There was no formal development process in place for nursing staff however there were ad hoc opportunities such as secondment posts. We saw that one member of staff had recently been seconded to the role of matron from nursing sister post in the department.
- Reception staff were mentored for 'as long as necessary' when new in post. This allowed them to build experience before working substantively. Reception staff were observed to identify patients who may require urgent medical assistance. They verbally alerted nursing staff and recorded the information.

Multidisciplinary working

- The departments worked regularly with a range of different agencies in providing care for patients.
- The Police were based in the ED on Friday and Saturday nights between 10pm and 4am to support staff and patients.
- A neighbouring trust checked and processed documentation completed by ED staff, for patients detained under the Mental Health Act.
- The service had previously been involved in multi-agency meetings regarding patients detained under the Mental Health Act, but this practice had stopped due to time constraints. Staff wanted to re-establish this link. Multi-agency meetings can help to mitigate the risk of people not receiving help because information has not been shared properly between organisations.
- There were internal links with oncology and substance misuse colleagues who could be contacted via the switchboard and would attend the ED if required.
- The service offered education to local care homes to avoid admission to hospital where appropriate.
- There were also links with the local ambulance service NHS trust. ED staff visited the local emergency operations centre and officers from the ambulance service would come to assist with flow if delays developed in the ED.

Seven-day services

- The main ED was always open. However, the CED was not open during the night from 11pm mid-week or midnight at weekends. When it was closed, children had to attend the main ED. There were no specific rooms for children except for a paediatric bay in the resuscitation area. The trust confirmed that children and young people requiring a trolley could be nursed in an area that had doors to provide audio and visual separation from adult patients.
- Consultants were present in the ED until at least midnight seven days per week and on an on-call basis at all other times.
- A middle grade doctor was available in the department 24 hours a day, seven days a week.

Access to information

- Medical, nursing and reception staff accessed patient information via multiple IT terminals located throughout the department.
- The electronic system gave details about the overall status of the ED as well as access to patient information such as previous attendance information, test results, and current observations. Paper records were also available which contained 'live' information such as case notes.
- Nursing staff said that CT scan results were received quickly.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw limited documented evidence that staff assessed a patient's capacity to understand their care and treatment. In three records we reviewed for patients whose condition (such as dementia or head injury) might reduce their capacity, this element of care was only recorded in one set of notes and there were no designated checklists or prompts to remind staff to check.
- When we queried this, staff told us that if they had cause to suspect a patient did not have capacity, they would ask a doctor to complete a formal assessment. However, we saw examples where some patients waited two hours to be seen by doctors. We were therefore unsure how long this would take if required.

Are urgent and emergency services caring?

Urgent and emergency services

Good

Patients were happy with the care provided and said staff were caring with a pleasant manner. Processes were explained to patients and relatives.

Reception staff made efforts to ease the process of attendance at ED for relatives by approaching them for details rather than them having to come to reception.

There were rooms available for relatives and loved ones to sit quietly, and for people to spend time with patients who had passed away.

Compassionate care

- The NHS friends and family test had produced positive results for the department with between 97% and 100% of people recommending the service between March 2014 and February 2015. However, the response rates for the service were low. Whilst this is not uncommon for an ED service the results may not provide a representative view of service users.
- The CQC Accident and Emergency (A and E) patient survey 2014 reviewed 250 patients who received care in the ED in 2014. The trust scored 8.7 out of ten for patients being given the right amount of information about their condition, 8.9 out of ten for being given privacy during examination or treatment and 6.2 out of ten for feeling reassured by staff when distressed.
- We observed staff talking to patients in a pleasant manner and they introduced themselves to patients in line with the national 'hello my name is' campaign which reminds staff of the importance of introducing themselves to patients.
- Patients told us that staff were 'kind, caring' and 'wonderful'.
- We saw one occasion when a patient's privacy was not maintained. When we alerted staff they rectified the situation immediately.
- The department used a symbol which was placed on the main door and outside cubicles to discreetly alert staff that a patient had passed away. This allowed staff to be respectful at all times.

Understanding and involvement of patients and those close to them

- In the 2014 CQC A and E patient survey, patients gave the ED a score of 7.7 for giving family or those close to them the opportunity to talk to a doctor if required.
- Patients in the department told us that processes were explained to them and that staff were pleasant.
- We saw that staff interacted with relatives and they reported their loved one being seen and assessed quickly.

Emotional support

- Reception staff approached relatives and loved ones to make the process of booking patients into the department easier. This avoided them having to leave the patient to go to reception themselves. The reception staff had access to six different computer terminals in the department to enable them to do this.
- The emergency department had two side rooms where loved ones could sit and have privacy during difficult times.
- There was also a bereavement room for people to spend time with their loved one away from the main areas of the department.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

National targets for access and flow through the department were repeatedly not met and patients did not always receive timely treatment.

The trust was struggling to achieve the standard that 95% of patients should be discharged, admitted or transferred within 4 hours, having only met the target once (July 2015) since December 2014, with a low of 78.6% in April 2015 to a high of 96.3% in July 2015.

In addition, the number of patients waiting between 4 and 12 hours for admission to hospital was worse than the national average between April 2014 and April 2015 and had risen over time.

Urgent and emergency services

For patients brought in by ambulance, the service consistently took longer to complete an initial assessment than the national average. This was compounded by frequent delays in ambulances being able to hand over patients.

At the time of our visit, the department was at times reaching capacity and we saw ambulances queuing to handover patients to staff.

Children's care was delivered in a designated children's emergency department (CED) during the day but this was closed at night, when children attended the main emergency department (ED).

Staff were aware of the needs of an ageing local population, many of whom had respiratory problems. Arrangements were in place to provide special care for patients living with dementia and with mental health needs. Staff knew how to handle complaints and looked at ways to reduce these but there was limited evidence that complaints information was regularly shared at senior level meetings.

Service planning and delivery to meet the needs of local people

- Services were planned to try to cope with demand. This included contributing to a local publicity campaign to signpost people to other services such as pharmacies or the GP. Despite this the emergency department (ED) still struggled to cope with demand on a daily basis.
- Managers and staff within the service were aware of the needs of local people. They reported that many patients were ageing and had complex respiratory problems.
- Plans were in place to meet the needs of people during winter such as securing community beds and sourcing staff to enable the opening of 'winter wards'.
- The children's emergency department (CED) provided an environment more suitable for children and adolescents, than the adult department. However, the department was only open between 9am and 11pm on weekdays and 10am until midnight at the weekend. Outside of those hours children had to be seen in the adult ED where the only designated room was a paediatric bay in the resuscitation area. The trust confirmed that children and young people requiring a trolley could be nursed in an area that had doors to provide audio and visual separation from adult patients
- Children's nurses were not always available when the CED was closed. However, general nurses and paediatric consultants were available or on call.
- Waiting times were not displayed to inform people how long they may have to wait to be seen. The staff occasionally used a tannoy system to convey this information but told us it was not used regularly for this purpose.

Meeting people's individual needs

- The service had two 'dementia champions'. Dementia champions are specially trained to care for patients living with dementia and act as a point of contact for other staff. The champions had links with the trust's dementia lead matron.
- There were two cubicles with coloured floors for patients living with dementia to use. This aims to enhance a patient's perception of the floor and walls.
- There were three side rooms available for patients living with a mental health condition which were deemed to be quieter than the main waiting areas. Only one of these rooms had en-suite toilet facilities.
- Patients requiring specialist intervention for their mental health needs were assigned to a clinical support worker with additional training, who remained with them whilst they were in the ED. Funding for the role had been increased, ensuring availability of one staff member 24 hours per day.
- The psychiatric liaison service was provided by a local provider of mental health service under a service level agreement and provided advice and support 24 hours a day for both the trust's hospital sites. They were based in close proximity to the ED with plans to move into the department itself.
- Patients in the 'trolleys' areas had either not been given call bells or they were out of reach. Nurses did not address this as part of intentional rounding (a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs). Call bells allow patients to summon help quickly if required. In all but two bays throughout the department, call bells were available but out of reach. This meant that patients had no way of summoning immediate help if required. We told senior staff about this and they took immediate action, placing call bells next to patients.

- For patients whose first language was not English, reception staff used a language book endorsed by the British Red Cross. This book covered a range of key phrases in a vast number of different languages. Telephone interpreters were also available.
- There was a range of information leaflets about different medical conditions such as head injury, which visitors could take away. However, these were all printed in English with no reference made to availability in other languages.

Access and flow

- The initial assessment area used a nurse led approach to triaging patients. The nurses used Manchester triage system (MTS) and modified early warning score (MEWS) systems to support decision making about where patients should go following initial assessment.
- Staff responsible for triaging patients with MTS relied on the system to generate the triage category but could not tell us what this category meant for the patient.
- The trust acknowledged that one of their biggest challenges was access and flow through the departments which was echoed by staff within the service. It had been listed as a risk on the departmental risk register and monitored regularly since June 2013.
- The service consistently failed to meet the Department of Health target requiring 95% of patients to be seen, treated, admitted or discharged in under 4 hours of attendance. The trust only achieved this target once between December 2014 and July 2015. Performance ranged from a low of 78.6% in April 2015 to a high of 96.3% in July 2015. Whilst there had been improvements in the number of patients seen within the time frame, by the end of August 2015 the percentage had dropped again, to 90%.
- In addition, the number of patients waiting between 4 and 12 hours for admission to hospital was worse than the national average between April 2014 and April 2015 and had risen over time. For example in May 2014, a national average of 5 patients waited compared with 13 patients in this trust. By April 2015 this figure rose to 35 patients against a national average of 10.
- For patients brought in by ambulance the service consistently took longer to complete an initial assessment (between 10 and 16 minutes) than the national average (between 3 and 6 minutes).
- Over the last five months the service reported 952 occasions when ambulance personnel waited longer than 30 minutes to hand over patient information.
- Between March 2014 and May 2015 the trust reported 609 occasions when ambulance personnel had to wait longer than 60 minutes to hand over patient details. This was worst in March 2015 when 36 delays of more than 60 minutes occurred.
- Senior staff explained that access and flow through the ED was dependent upon the capacity to admit patients (available beds) within the hospital. The trust's patient flow workgroup focused on strategies to maintain flow. These included introducing daily ward reviews to identify patients ready for discharge, collaboration with social services, implementing early supported discharges and delaying any long term plans to reduce the number of beds within the hospital.
- The trust used a policy which identified key triggers for escalation based on demand and changed bed capacity. Triggers included 50 or more patients present in the department, or 10 patients awaiting medical beds in the department by 8am.
- Patients for whom beds could not be found in the hospital were often placed into the emergency department review unit (EDRU) and known as 'outliers'. This contributed to the EDRU being full at times which limited the department's ability to maintain flow. Following review, a report provided by the NHS Emergency Care Intensive Support Team (ECIST) in April 2015, recommended that the EDRU be used more for its intended purpose, which was to observe patients for a maximum of 12 hours following ED attendance. However, this did not always happen due to daily capacity issues within the hospital.
- ED staff attended regular 'bed meetings' every two hours to discuss bed status and capacity within the hospital. There were also hourly 'huddle' meetings within the departments to review capacity and flow.
- Delays also occurred when senior doctors were not available to authorise the admission or discharge of patients, and when beds within the hospital were not available. We saw evidence of both of these issues during our inspection and 45 incidents about delays were recorded between March and June 2015.

Learning from complaints and concerns

- Between December 2014 and June 2015, complaints about the emergency departments accounted for 19%

of those received by the trust in total. The majority of complaints (38%) related to a lack of communication between staff and patients. Staff attitude accounted for 18% of complaints and delays in treatment accounted for 17%.

- Clerical staff were able to explain the process of complaint handling and that complaints were resolved at the time of an incident if possible by summoning nursing staff. Should someone wish to make a formal complaint the staff had access to leaflets explaining the process in more detail.
- Senior staff had drawn conclusions about possible causes of attitude related complaints such as peaks in pressure within the department and took action to improve this by introducing individual staff welfare checks which senior staff said had reduced complaints.
- The service showed a willingness to learn from complaints, recently welcoming a complainant into the department to speak to staff about their experience.
- We reviewed minutes from divisional clinical governance meetings held between February and June 2015. There was no evidence that learning from complaints were shared or discussed at these meetings.

Are urgent and emergency services well-led?

Requires improvement

The department was rated as requiring improvement, particularly in relation to measuring quality and minimising risk.

Quality measurement within the department was limited. Staff were not aware of any regular robust quality measures used to improve outcomes but they did have knowledge of national targets.

A risk register was in place and was monitored, but actions to manage and mitigate these risks were not always undertaken in a timely way. For example, we saw that the need for an audit was identified in January 2014 but this hadn't been completed at the time of the inspection, over 18 months later.

Staff were aware of the service vision and were able to contribute to this because managers engaged with these staff, winning an award for their work. Engagement was also evident with the public. Innovative work for electronic prescribing was in progress.

Vision and strategy for this service

- Staff understood the trust values which included dedication, respect and ownership under the acronym; 'PROUD'. We saw these displayed at points around the department.
- Staff talked about the trust's vision to refurbish the department and were excited about the next phase.
- Senior staff spoke of their strategy to introduce a 'single point of access service' which would involve having GP's within the emergency department and seven day working between 7am and 7pm. Work to achieve this was in progress at the time of our inspection.

Governance, risk management and quality measurement

- Monthly governance meetings were in place where mortality, incidents and actions were discussed. Information was then cascaded to senior staff via email to enable sharing with other staff.
- The department had a risk register which identified risks, actions to mitigate risk, progress and review dates. Items on the risk register reflected those highlighted by staff such as staffing levels, and difficulty achieving the 4 hour target for admission, treatment, transfer or discharge of patients. It also highlighted risks that compliance with some NICE guidelines such as the triage, assessment, investigation and early management of head injury in children, young people and adults, would not be met. There was an action from September 2014 to review compliance but by June 2015 this had still not been completed. Actions to manage the risk of non-compliance with alcohol related disorders guidelines and transient loss of consciousness in adults and young people guidelines, were taking time to progress. For example, it was identified that an audit of compliance with the guidelines was required in January 2014, but according to the register, it took until July 2014 for a nominated lead to be assigned. The audit was noted as being started in December 2014 but at the time of the inspection, it hadn't been recorded as complete, over 18 months later.

Urgent and emergency services

- Quality was measured in terms of national targets with limited knowledge in the department of local audits.
- When patients were brought into the department by the Police, risk assessments were carried out to decide how long the police would remain with the patient.
- Staff were kept safe at work with windows at reception and panic buttons placed strategically around the department. The panic buttons were regularly tested in partnership with security services on site and the results were recorded. Some staff also carried personal alarms with them.
- Security staff were trained in control and restraint practice and some staff within the service were also trained. However, there was no formal process to help staff decide whether restraint was necessary.

Leadership of service

- The department was part of the medicine and acute division, led by a divisional director, medical director and director of nursing. Each division was led by a clinical service lead who for the emergency department (ED) was one of the ED consultants supported by two matrons.
- Staff knew who their line managers were and most felt that senior management staff were approachable and supportive.
- One staff member did not feel supported by management despite efforts being made to improve the situation following issues being raised.

Culture within the service

- Staff felt valued and enjoyed working for the trust.
- There was an emphasis on promoting the safety of staff and actions were taken when staff wellbeing issues were raised.
- There was a culture of candour and honesty in the service.
- We saw staff liaise with each other in a friendly and supportive manner in the ED

Public engagement

- The service contributed to a campaign called 'A&E won't kiss it better' to try to reduce inappropriate attendances by describing options for problems ranging from headaches, to sprains and strains as well as potentially life threatening conditions such as difficulty breathing. The campaign proved a success, lowering the numbers of attendance to the emergency departments by approximately 3000 annually.
- Posters were displayed in the children's emergency department (CED) which provided information to help keep children safe. For example, recommendations to keep bleach out of reach, and information about drowning and dog bites.

Staff engagement

- Senior management engaged with staff to capture views about refurbishment in the departments. This approach was part of the trust's 'listening into action' strategy which won a national award in November 2014.
- The service also used an initiative called 'schwartz rounds' to involve staff in planning for winter. Schwartz rounds are a nationally implemented tool to improve the culture of organisations by reflecting on emotional aspects of work.

Medical care (including older people's care)

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

Information about the service

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

We visited Arrowe Park Hospital as part of our announced inspection on 16 September to 18 September 2015. We also visited the hospital as part of our unannounced inspection in the evening of 24 September 2015.

During the inspection, we visited ward 16 (older people's assessment unit), ward 22 and 23 (care of the elderly), ward 26 (diabetes) ward 31 (renal dialysis), ward 33(cardiology), ward 36 (gastroenterology), coronary care unit (CCU), medical short stay unit, acute medical unit, ambulatory care and the endoscopy unit.

We reviewed the environment and staffing levels and looked at 29 care records and 28 prescription records. We spoke with two family members, 22 patients and 50 staff of different grades, including nurses, doctors, ward managers, occupational therapists, a social worker, a domestic assistant, and the senior managers who were responsible for medical services.

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

Summary of findings

We previously inspected this hospital in May 2015 and found that there were shortages of nursing staff on some medical wards. Whilst staffing levels had improved, we found that medical services at Arrowe Park Hospital required improvement overall. This is because we found concerns in relation to safety, responsiveness and leadership of the service.

Incidents were reported by staff but the reasons why changes had been made following investigations were not always communicated effectively to all staff.

Staffing levels had improved since the last inspection but there were concerns in relation to nursing staffing on some of the wards at night and the medical short stay ward. Clinical staff had access to information they required, for example diagnostic tests and risk assessments, however, where agency staff were used, they were not always able to access information on the electronic care record about patients they were supporting. There were standards for record keeping that required improvement but records did include a treatment plan for each patient.

There were a large number of patients being cared for in non-speciality beds and clear procedures or policies were not in place to help manage care for these patients. The trust did not monitor the reason for moving patients between wards and could therefore not clarify whether the moves were made for clinical reasons.

Medical care (including older people's care)

Patients experienced a longer (worse) length of stay than the England average and there were significant numbers of people who were experiencing delayed discharge because they were waiting for packages of care and could not be discharged by the hospital until funding had been agreed for this care. The hospital was working with partner organisations to look at ways to decrease the number of delayed discharges.

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

Multidisciplinary team meetings were not held on regular basis on all wards which meant that important information was not shared formally or discussed by all members of the care team. All staff knew the trust vision but were unaware of the strategy for medical services. We saw limited evidence that information was collected and analysed to support clinical and operational decisions.

Best practice guidance in relation to care and treatment was usually followed and medical services participated in national and local audits.

Nursing staff and senior management staff were unclear about the procedures to follow when reaching decisions about using bed rails which are a form of restraint.

We observed care and found this to be compassionate from all grades of support and clinical staff, though there was limited interaction with patients on ward 24. Where possible, patients were involved in their care and treatment and could access emotional support if they needed to.

The majority of staff said they felt supported and said that morale in medical services had improved over the past six months.

Are medical care services safe?

Requires improvement

We previously inspected this hospital in May 2015 and found that there were shortages of nursing staff on some medical wards. Staffing levels had improved since our last visit. However, there were still some staff vacancies which were noted on the risk register. Action had been identified to mitigate the risks. There were still wards where the nurse staffing levels were not always sufficient to meet the needs of patients. This was on wards 16, 24, 36 and the medical short stay ward. In addition, staff on the coronary care unit were not assessing the acuity of patients on a regular basis to ensure there was the appropriate skill mix of staff required.

Incidents were reported by staff through effective systems and staff were aware of lessons learnt or improvements that had been made following investigations. However, the wider sharing of the learning and the reasons why changes had been made was limited. There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse but senior management staff were not aware of who investigated referrals made to the safeguarding team.

Medical wards at the hospital were generally visibly clean and staff followed good hygiene practice, although we did see unclean toilet areas and equipment on the medical short stay ward. Similarly, in the discharge lounge, we found sheets that were not clean.

There was good monitoring of infections, although we did not see any evidence of actions to improve standards. Cleaning chemicals were left out in an unlocked room on a number of wards and there were trolleys containing sharp instruments that were not locked away and had been left unattended.

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

There were systems in place to manage the safe administration and prescribing of medication. Audits had

been undertaken but actions had not always been identified to help staff improve when standards had not been met. There were some medication errors in medical services but none of them had been recorded as high risk.

Staff attended mandatory training courses but compliance rates were below the trust target. There were effective systems in place to assess and respond to patient safety risks.

Incidents

- Staff were familiar with and encouraged to use the trust's policy and procedures for reporting incidents. Incidents were reported through the trust's electronic reporting system and we spoke with a range of staff across the service who were all aware of how to report incidents.
- A root cause analysis tool was used to investigate serious incidents, and we saw that where required an action plan was put in place to reduce the risk of the incident happening again. Action plans included evidence of feedback and actions for learning. Where necessary, action plans indicated where further training for staff was required. However, on reviewing five of these reports it was found that although they contained the majority of the sections outlined in the national patient safety agency (NPSA) guidelines, such as action plans, they did not include arrangements for wider shared learning across the trust.
- Staff were able to provide us with examples of when they had reported incidents, and understood what constituted an incident. For example, when a patient had fallen or when medication had been missed as a patient was off the ward for clinical investigation.
- In the last 12 months medical services at the hospital reported one never event in August 2014. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Seeking to learn, the trust undertook an investigation using a root cause analysis process. An action plan had been identified which outlined key actions for improvement which had been implemented.
- Between March 2015 and June 2015 medical services across the trust, including older people's care, reported 569 incidents. Of these, 41 related to staffing levels in medical services at the hospital.
- Between May 2014 and June 2015 there had been 38 serious incidents reported throughout medical services at the hospital. Information provided by the trust showed slips, trips and falls were the most commonly occurring incident followed by pressure ulcers and delayed diagnosis.
- Senior staff told us general feedback on patient safety information was discussed at ward staff meetings or in staff huddles. On the wards we visited senior staff facilitated time with ward staff to look at lessons learnt from incidents.
- Staff told us they received feedback from incidents they had reported via email and the outcome of Investigations was also received from senior staff, however, the rationale for any changes were not always explained. Staff were able to describe an example of a change following an incident where the nurse's desk was moved to the centre of the ward following a number of falls.
- Information about incidents was discussed for medical care as part of clinical governance meetings each month, but it was not always clear how identified learning was going to be cascaded to ward staff or whether it had already been shared.
- Incidents were not discussed during the May 2015 divisional management team (DMT) business performance meeting. The clinical governance meetings reported into the DMT meeting and the terms of reference for this meeting included considering trends in relation to incidents and to consider escalation of concerns about compliance with root cause analysis actions. It did not appear that incidents were being considered in the DMT meetings.
- Mortality and morbidity themes and trends were discussed as part of the service clinical governance meeting; however, it was unclear if any actions for improvement were agreed at the meeting.
- Senior staff were aware of their responsibilities relating to Duty of Candour legislation and were able to give us examples of when this had been implemented. The trust had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence. The aim of the duty of candour regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.

Medical care (including older people's care)

Safety thermometer

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

Cleanliness, infection control and hygiene

- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures. There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice, bare below the elbow and using personal protective equipment where appropriate.
- Between March 2015 and August 2015 the trust reported 21 cases of clostridium difficile infections, two cases of MRSA and six cases of MSSA.
- We observed good infection control practices, processes and procedures for the management of carbapenemase-producing enterobacteriaceae (CPE) on ward 14. CPE is an antibiotic resistant infection.
- Wards used the 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use. However, on the medical short stay ward there were four blood pressure machines that had the 'I am clean' stickers on but on checking the equipment they were still dirty and dusty.
- Although the majority of wards we visited were visibly clean and free from odour, we observed that cleaning of the environment was not always as thorough as it should have been. On the medical short stay ward we saw that a bathroom had not been thoroughly cleaned and the toilet in the discharge lounge was also dirty. We pointed this out to senior staff who contacted domestic staff to rectify this.
- We saw dirty and stained sheets on the beds in the discharge lounge which had been prepared for patients who required a bed whilst waiting for discharge. We raised this with senior staff who disposed of the sheets.
- Monthly infection control audits were undertaken across all wards which looked at standards such as cleaning schedules and if hand wash basins were accessible, in a good state of repair and clean We looked at the results of three audits which showed that ward 38 was 82% compliant with the standards, ward 22 was 95% compliant and ward 16 was 89% compliant. However, no actions were identified on the audit tool to improve infection control standards despite all of the wards being below 100%.
- Weekly hand hygiene audits were undertaken by staff being observed. Results were mostly around 100% across medical and care of the elderly wards. If the results were below 100% ward managers were told to raise this with staff individually.
- All wards had antibacterial gel dispensers at the entrances and by people's bedside areas and that appropriate signage, regarding hand washing for staff and visitors, was on display.

- Side rooms were used where possible as isolation rooms for patients at increased risk of cross infection. There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room.
- We observed that the disposal of sharps, such as needle sticks followed good practice guidance. Sharps containers were dated and signed upon assembling them and the temporary closure was used when sharps containers were not in use.
- Cleaning schedules were in place and had been completed as required. Wards were using the national colour coding scheme for hospital cleaning materials and equipment so that items were not used in multiple areas, therefore reducing the risk of cross infection.

Environment and equipment

- In order to maintain the security of patients, visitors were required to use the intercom system outside wards to identify themselves on arrival before they were able to access the ward and staff had access codes.
- Most areas we visited were bright and well organised, however when we visited the discharge lounge it was sparsely furnished and felt empty and unwelcoming for patients who may have to sit in the area for a number of hours waiting to be discharged. There were only eight chairs and three beds for up to 56 patients a day.
- Each clinical area had resuscitation equipment readily available. There were systems in place to ensure it was checked and ready for use on a daily basis. Records indicated that daily checks of the equipment had taken place on the wards we visited.
- Throughout our inspection we did not identify any major environmental risks or hazards. However we did notice that some ward areas were not as spacious as others, for example on ward 33 an assisted bathroom was being used as a storeroom. The ward manager told us that there was a walk in shower room that could be used by patients and that the area had been identified for future refurbishment into a purpose built storeroom. There was also a large hole in the wall on ward 23 and flooring in poor condition on the medical short stay ward. This had been reported six months ago and was on the programme of ward refurbishment but it was not clear when this work would be carried out.
- There were systems to maintain and service equipment as required. Records indicated that defibrillator equipment had been checked and hoists had been serviced regularly. Portable appliance testing had been carried out on electrical equipment regularly and electrical safety certificates were in date.
- Cleaning chemicals were left in an unlocked area on wards 22 and 16. These should have been stored securely as the chemicals were potentially hazardous and presented a risk to people's health.
- On ward 33 and in the discharge lounge, portable oxygen cylinders were not stored in a locked room or secured in a cage or against a wall. Health and safety best practice guidance is that oxygen cylinders should be stored securely in a well ventilated storage area or compound when not in use.
- On ward 24, the sluice room did not have a lock on it and the doors to the isolation ward were not lockable. This meant that patients may have been able to walk into an area where people were being isolated to prevent the risk of cross infection. We were told that the ward was due for refurbishment later in 2015 but the ward manager was unsure if this included locks to the sluice room or the isolation ward.
- On ward 24 there were needles and scissors stored in a room that was not locked and accessible to patients and the public.
- On wards 23,36 medical short stay ward, needles and sharp instruments were in an unlocked trolley which was accessible to patients and the public
- Patient led assessments of the environment (PLACE) in 2014 showed a standard of 96% in the trust for condition, maintenance and appearance.

Medicines

- Medicines were prescribed electronically throughout the medical specialities and the care of the elderly wards.
- Between August 2014 and September 2015 there had been 332 medication errors reported in medical services across the trust. Of those, 270 reported the primary cause as prescribing and 75 had the primary cause as administration. Medication errors were categorised into low, moderate or high risk. None of the reported errors were recorded as high risk.
- Medication errors were discussed at the clinical governance meeting although it was unclear what

learning had taken place. Actions to address the trends identified from 2012/13 incidents were only just being formally discussed in March 2015. This meant there was a risk that learning was not happening in a timely way.

- We looked at the prescription and medicine records for 28 patients. We saw arrangements were in place for recording the administration of medicines. These records were clear and fully completed. However, the way the trust's electronic recording system was set up it was difficult to find the original prescriber of the medication.
- Medicines requiring cool storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were consistently completed on the wards we visited. However, staff told us they were not aware of the process to follow if there were gaps in these records.
- Controlled drugs (medicines which are required to be stored and recorded separately) were stored and recorded appropriately. Access was limited to qualified staff employed by the trust. Two nurses were observed following the correct procedures for the recording and administration of controlled drugs for a patient.
- Emergency medicines were available for use and records indicated that these were regularly checked and were in containers with tamper-seals in place.
- We observed medication rounds on the short stay medical unit and ward 33. We heard nurses ask patients their name and date of birth before administering medication. This helped staff to ensure they were giving prescribed medicines to the correct person.
- Where patients were able to, they administered their own medication. We spoke with one patient who had been provided with a lockable drawer in which to store their medication, the patient was able to continue to take their medication at the times they were used to taking the medication at home. This meant that patients were given a choice and steps were taken to maintain their independence.
- There was a pharmacy top-up service for medicines that the ward stocked and other medicines were ordered on an individual basis.
- A pharmacist visited medical wards each week day. Pharmacy staff said they checked that the medicines patients were taking when they were admitted to the wards were correct and that records were up to date.
- Pharmacy staff were readily available in the discharge lounge to provide medicines to patients to take home.
- There were matron monthly medicines management audits which looked at compliance with storage of medicines. We looked at the findings for August 2015 audit and saw that out of 16 medical wards at the hospital audited only nine met all the standards. The audit results showed that only two of these wards had an action identified for the ward sister to implement.

Records

- We reviewed 29 care records. We saw that recent entries were legible, signed and dated. They were easy to follow and medical staff had detailed information for patient's care and treatment. Documentation kept to record people's vital signs, fluid balance charts and food intake were fully completed.
- On ward 14 we saw that there was loose paper containing patient information in a medical record we reviewed. This meant there was a risk that important information may get mislaid.
- The hospital used paper-based and electronic records. Patient records included a range of risk assessments and care plans that were completed on admission and were updated throughout a patient's stay.
- We observed that for each patient there were up to three sets of records which were a mixture of paper based records and electronic records. This meant there may be a risk that important information may be difficult to find in an emergency.
- Wards had lockable patient note trolleys. On wards 23, 22, 16 and 36 we observed that these trolleys containing patient notes were left opened and unattended in the corridors. This increased the potential for patient confidentiality to be breached. On other wards we visited patient note trolleys were not left unlocked or unattended.
- The trust recently reintroduced monthly medical records audit. We reviewed the information between June 2015 and September 2015. Medical services trust wide fell below the 75% compliance target in six of the standards. For example, out of the records reviewed in August and September only 35% had the patient NHS number on each page which is a key patient identifier. However all the records reviewed did have a treatment plan. The trust recommended services put in place action plans to improve compliance levels.
- The trust implemented the new electronic record system to record all aspects of patient care. Staff told us that there were areas in the hospital where it was

difficult to maintain Wi-Fi connection for laptops and portable tablets. Doctors told us that this often meant that patient information was not always being saved effectively and that information had to be recorded again. This meant there was a risk that important information may not be on the system or duplicate information may be recorded.

- A nurse told us they did not know how to use the electronic patient record and wrote things down on a piece of paper and asked other staff to input onto the system. This meant there was a risk that patient information may not be correctly recorded in a timely way.
- The patient information boards that were visible in ward corridors respected patient confidentiality by patient names being covered up. Patient information boards were used to provide at a glance an overview of the key risks, medication and discharge plans for each patient.

Safeguarding

- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse. The trust had a safeguarding team which provided guidance during the day in the week. Staff had access to advice out of hours and at weekends from the hospital co-ordinator or the local authority duty social worker.
- Between April 2014 and April 2015 there had been 900 referrals made to the trust safeguarding team which was a 5% increase from the previous year for medical services across the trust
- Training statistics provided by the trust showed that in medical services trust wide 65% of medical staff and 76% of nursing staff had completed safeguarding level 1 training. 78% of medical staff and 70% of nursing staff had completed safeguarding level 2 training with only 20% of nursing staff who had completed safeguarding level 3 training and no medical staff had completed safeguarding level 3 training. The trust target was 90%.
- Basic Safeguarding training was included in induction training for all temporary staff before commencing work on the wards.
- Senior managers we spoke to did not have a clear understanding of the trust safeguarding policy as they told us that all safeguarding referrals were investigated by the trust safeguarding team. However, the policy showed that safeguarding referrals were to have a multiagency investigation led by a local authority social worker. This was confirmed when we spoke to a social worker in the integrated discharge team.
- The senior management team told us that they did not receive feedback from any safeguarding referrals that were made, however social worker staff told us that they provide feedback on every referral to the trust safeguarding team.
- Staff on the wards told us that they did receive feedback from safeguarding referrals that they made but did not get feedback or learning from other safeguarding referrals.

Mandatory training

- Staff received mandatory training on a rolling 18 month programme (block B) in areas such as infection control and medicines management and a three year rolling programme (block A) in areas such as safeguarding, manual handling and fire. At the time of our inspection, 76% of staff in medical services across the trust had completed their required mandatory 18 monthly training and 90% of staff had completed their required three yearly training. The trust target was 95%.

Assessing and responding to patient risk

- A modified early warning score system (MEWS) was used throughout the trust to alert staff if a patient's condition was deteriorating. This was a basic set of observations such as respiratory rate, temperature, blood pressure and pain score used to alert staff to any changes in a patient's condition.
- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required, staff had escalated their concerns. There was a medical emergency outreach team which was used for patients whose early warning score was above a certain level (a score of seven or above). Repeated checks of the early warning scores were documented accurately.
- Upon admission to medical wards, staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care. The risk assessments included falls, use of bed rails, pressure ulcer and nutrition (malnutrition universal screening tool or MUST).

- Intentional observation rounds were carried out by nurses every two to four hours depending on individual need to assess patient risk on an ongoing basis. On Ward 24 we saw that for two patients these had not been completed accurately and it was unclear if these had been undertaken.
- The trust undertook a modern matron ward round every month where the allocated matron visited the ward area to look at leadership, documentation, patient safety, and nutrition and infection control.
- The matron ward round documentation for the medical short stay ward showed that the overall score for the standards being met had fallen from 93% in April 2015 to 87% in May and June 2015. For ward 33 the score was 62% in August 2015. The documentation provided by the trust did not include any actions needed to improve the overall score and patient care. However, the trust told us that matrons kept their own action plans separately and followed up results with staff to improve standards.

Nursing staffing

- Nurse staffing levels had improved since the last inspection with a number of vacancies now filled. Matrons met each day to discuss nurse staffing levels across medical services to ensure that there was good allocation of staff and skills were appropriately deployed and shared across all wards. In July 2015 there were still 70 nursing vacancies in medical and acute services and this was recorded on the risk register. There were actions identified to mitigate this risk such as a rolling recruitment programme. Managers knew where there were shortfalls and where there was surplus on other wards so that staff that could be called on if needed.
- Each ward had a planned nurse staffing rota and reported on a daily basis if shifts had not been covered. The National Institute for Health and Care Excellence (NICE) guideline 'Safe staffing for nursing in adult inpatient ward in acute hospitals' was used by the trust. However, not all wards were consistently implementing these recommendations.
- Staff on the coronary care unit (CCU) looked after patients who needed level one and level two care. They were not assessing the acuity of the patients on a regular basis in line with the intensive care unit criteria to determine if they were level one or level two patients. This should be been done to ensure appropriate skill mix of staff. Level two patients require higher levels of care and more detailed observation and intervention. On the day of the inspection, patients on CCU were requiring level one care.
- Nursing staff raised concerns about staffing levels across medical services at the hospital and told us they were moved around on a regular basis to fill staff shortages on other wards, even though this meant their ward would also be left short.
- We saw evidence that between 24 August 2015 and 14 September 2015 staff had been moved from the medical short stay ward to another ward seven times.
- Not all staff felt confident about working on unfamiliar wards, but most understood the need to maintain safe staffing levels across the hospital.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirement.
- The trust had a target that 95% of nursing shifts should be filled as planned during the day and night. We reviewed staffing figures for ten medical wards. Between June 2015 and August 2015 there were only three wards out of ten where the average number of nursing shifts filled as planned was meeting this target. Wards 22, 26 and 32.
- The average percentage of nursing shifts filled as planned during the day between June 2015 and August 2015 for the remaining seven wards, were above 90% except for ward 33 at 86%.
- The average percentage of nursing shifts filled as planned during the night between June 2015 and August 2015 for the remaining seven wards was variable. There were concerns over ward 24 at 88%, ward 38 at 84%, ward 36 at 82% and ward 16 at 79%.
- Ward sisters had been working clinically on some shifts and additional clinical support workers had been deployed on some shifts at night to maintain safe staffing levels but his was not always the case. For example on ward 16 there were 18 nights in July 2015 when this did not happen. Between June 2015 and August 2015 there had been 25 incidents reported due to staffing levels in medical services at the hospital.
- On the evening of the unannounced inspection, we saw that on ward 24 there were two nurses due on night duty for 33 patients, as this ward had additional beds

occupied due to the isolation area being opened as a medical ward because of an increased demand on beds. We saw that an additional bank nurse arrived for duty but did not have the required access to the electronic system which meant they would have been unable to complete patient assessments. We raised this with senior management staff who ensured that there was an adequate number of nurses on duty that night.

- During the unannounced inspection we looked at the staffing levels on the medical short stay ward for the previous six days. The percentage of nursing shifts filled as planned during the day was 72%. However, all nursing shifts were filled as planned at night. Due to the staffing levels in the day part of the ward which was used for general practitioner referrals was closed four times. This meant that there was only one area open for general practitioner referrals, which was on the acute medical unit or patients were referred to the emergency department.
- The acute medical unit and the medical short stay ward had two additional nurses doing twilight shifts to help with busy periods. These shifts were not always filled as planned. For example in July 2015 the percentage of shifts filled was 62%.
- The vacancy rate for nursing staff in medical services trust wide was 13% at the time of the inspection. The turnover of nursing staff was 9.7%.
- Wards allocated at least one qualified nurse to each bay to get to know the patients and provide a constant presence within the bay.
- The trust was reliant on bank nurses to fill shifts that were not covered. Nursing and medical staff told us they couldn't rely on agency nurses because they were not familiar with the trust's electronic recording system. The trust were due to move providers for bank nurses as the number of staff available was significantly below the demand of the hospital with only 55% of requests being met.
- We observed a nursing handover between staff on two medical wards. The quality of handover was variable, one included all nursing staff and one just included the ward sister. However relevant information was handed over to the incoming staff.

Medical staffing

- Rotas were completed for all medical staff which included out of hours cover for all medical admissions and all medical inpatients across all wards. All medical trainees contributed to this rota. The information we reviewed showed that medical staffing was appropriate at the time of the inspection.
- Patients reported that they did not always see a doctor at the weekends, although there was sufficient cover outside normal working hours and at weekends.
- There was an on call rota which ensured that there was a consultant available 24 hours a day seven days a week for advice.
- The percentage of consultants working in medical services trust wide was 35% which was higher (better) than the England average of 34%. The percentage of registrars was 31% which was below (worse) the England average of 39%. The percentage of junior doctors was 30% which was higher (better) than the England average. Middle grade levels were about the same as the England average.
- The vacancy rate for medical staff was 18% and the turnover of medical staff in medical services trust wide was 18% at the time of the inspection.
- There were still some medical staffing vacancies in medical services and this was on the trust risk register. There were actions identified to mitigate this risk such as a recruitment programme.
- The total number of shifts covered by locum medical staff in medical services trust wide, between April 2015 and September 2015, was 1428. This was for a number of reasons including, vacancies, extra staffing over and above the normal levels and extra ward rounds. Locums were either trust staff working extra shifts or from an agency.
- We saw a ward round which was attended by the consultant as well as junior doctors and there was effective verbal communication between each other and the patients.

Major incident awareness and training

- There were documented major incident plans within medical areas and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff were aware of what they would need to do in a major incident and knew how to find the trust policy and access key documents and guidance.
- At the time of the inspection, a number of dialysis machines were not working and plans were put in place

to ensure that patients received dialysis. This included working with other organisations. The ward sister managed the situation well. However, it was noted that there was no standard operating procedure in place should this happen again. Staff told us that a similar situation had happened in February 2015 and an investigation was undertaken but they were unaware of the findings or any actions taken. Staff told us that risks relating to the dialysis equipment had been identified and were on the risk register. However, there were no risks related to dialysis equipment recorded on the risk register for medical services.

Are medical care services effective?

Good

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

The endoscopy unit had been awarded Joint Advisory Group (JAG) accreditation and the unit was open six days a week.

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

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

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

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

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

We found that staff members' understanding and awareness of assessing people's capacity to make decisions about their care and treatment was largely good, however they did not recognise the principles in relation to the use of bedrails and trust documentation was not clear about recording the use of bedrails in relation to the mental capacity act.

Evidence-based care and treatment

- The service used national and best practice guidelines to care for and treat patients. The trust monitored compliance with National Institute for Health and Care Excellence (NICE) guidance and were taking steps to improve compliance where further actions had been identified.
- The service participated in all of the clinical audits for which it was eligible through the advancing quality programme. In February and March 2015 audits demonstrated the trust were not meeting the appropriate care score threshold for sepsis and for chronic obstructive pulmonary disease (COPD). Action plans were completed following clinical audits to address any areas identified for improvement.
- Care pathways were in place for managing patients that needed care following a stroke and for patients who received ambulatory care (ambulatory care is medical care provided on an outpatient basis). The ambulatory care pathways included care of patients with cellulite, pulmonary embolism (PE) and deep vein thrombosis (DVT). The care pathways were based on NICE guidance.
- There were examples of recent local audits that had been completed on the wards. These included documentation and discharge audits. Senior staff said they received the results of the audits and any learning was shared with them via email.

Pain relief

- Pain relief was managed on an individual basis and was regularly monitored. Patients told us that they were consistently asked about their pain and supported to manage it.
- We saw that the level of pain patients were in was recorded on early warning scores documentation.

- We did not see any evidence that there was any specialised tools in place to assess pain in those who had a cognitive impairment such as dementia or a learning disability.

Nutrition and hydration

- A coloured tray system was in place to highlight which patients needed assistance with eating and drinking. The mealtime co-ordinators communicated with the catering staff and ensured all patients received a meal. The trust had an internal target to ensure that 75% of patients got assistance with eating when they required it. Information provided by the trust showed that they were not meeting this target. The trust had taken a number of actions including practical measures such as opening sandwich packets for patients and cutting the sandwiches into small triangles and providing soft fruits which were easier to eat.
- Fluid balance charts were mostly fully completed and we saw from the records we looked at that patients had had an assessment of their nutritional needs and referred to a dietician where necessary. Where required, patients received nutritional supplements.
- The majority of patients we spoke with said they were happy with the standard and choice of food available. However a number of patients told us that lunchtime meal were sandwiches and soup only. If patients missed a meal as they were not on the ward at the time, staff were able to order a snack bag for them.

Patient outcomes

- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. MINAP audit results for 2013/14 for this trust showed the number of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI-a type of heart attack that does not benefit from immediate PCI) seen by a cardiologist prior to discharge was better than the national average at 95%. 78% of patients with an N-STEMI were admitted to a cardiology ward. This was better than the England average of 55%.
- The sentinel stroke national audit programme (SSNAP) latest audit results rated the trust overall as a grade 'A' which was an improvement from the previous audit results when the trust was rated as a grade 'B'. Since October 2014, the trust had either been ranked first or second regionally in the SSNAP audit. The trust had actions in place to improve care. These included dedicated stroke beds 'out of beds escalation policy' and weekly meetings to discuss the patient journey for people who'd had a stroke.
- The 2012/2013 heart failure audit showed the hospital performed better than average for all four of the clinical (in hospital) indicators and in all of the seven clinical (discharge) indicators.
- In the 2013 national diabetes inpatient audit (NaDIA) the trust was better than the England average in 13 of the 21 indicators. The trust performed worse than the England average in foot assessments.
- The endoscopy unit had been awarded Joint Advisory Group (JAG) accreditation. The accreditation process assesses the unit infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines. The unit was open six days a week.
- The unit had become a local provider for Wirral patients in the national Bowel Cancer Screening Programme. The aim of this was to help reduce the incidents of bowel cancer and achieve earlier diagnosis.
- The average length of stay for elective medicine at the hospital was longer (worse) than the England average at 12.6 days from January 2014 to December 2014. The England average was 4.5 days. For non-elective medicine it was shorter (better) than the England average at 6.2 days. The England average was 6.8 days.
- The readmission rates for the hospital was worse than the England average in gastroenterology, nephrology, geriatric medicine and clinical haematology but better than the England average in respiratory medicine and diabetic medicine.
- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to England. A score of over 100

means more adverse (worse) outcomes than expected and a score of less than 100 means less adverse (better) outcomes than expected. Between October 2013 and September 2014 the trust score was 97.

Competent staff

- Staff told us they received an annual appraisal. According to trust figures 99% of medical of staff in medical care services across the trust had received their annual appraisal and 79% of nursing staff. The trust target was 85%.
- The trust did not have a clinical supervision policy. Qualified staff told us there were no formal systems for clinical supervision. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. However, nurses told us that they did have regular meetings with their manager and they were able to speak to their manager at any time.
- Staff we spoke with confirmed they had an adequate induction. Newly appointed staff said that their inductions had been planned and delivered well.
- There was a preceptorship programme which supported junior nursing staff. Their competency in undertaking care procedures was assessed by qualified staff.
- The trust was involved in the apprenticeship nursing scheme with the skills for health academy. Cadet nurses were undertaking a national vocational qualification in care. This helped ensure that any future applications for nursing posts were from competent people who had the skills and experience required. The trust had recently become the employer of the year for apprenticeships.
- Staff in bands 1-4 were offered opportunities to undertake appropriate vocational qualifications; however there was no service overview of which staff had gained such qualifications.
- Medical services ensured that healthcare support workers undertook the care certificate. Six new ward based healthcare support workers in medical services had begun this qualification. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles such as healthcare assistants.
- We saw that there was a range of specialist nurses, for example a matron for dementia. Staff told us they knew how to contact these specialists and felt supported by them.
- A ward sister told us that they had recently been moved to manage a ward on a temporary basis but had not received any training in the speciality they were now managing. They had received training in managing sickness and attendance.

Multidisciplinary working

- Multidisciplinary team (MDT) working was established on the medical wards. We saw a good example of MDT meetings on the medical short stay ward and these were attended by the ward manager, nursing staff as well as therapy staff such as a physiotherapist and occupational therapist. However, these were not held regularly on each medical ward.
- Ward teams had access to the full range of allied health professionals and team members described good, collaborative working practices. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date. This was particularly evident on the stroke ward.
- A psychiatric liaison service was available within the trust which provided advice and support to staff.
- Meetings about bed availability were held four times a day to determine priorities, capacity and demand for all specialities. These were attended by both senior managers and senior clinical staff.
- Daily ward meetings were held on most of the wards we visited. These were called board rounds and they reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge. We observed two board rounds and saw that they were well attended by a range of professionals.

Seven-day services

- There were links with social services in place to ensure the clinical teams were fully supported seven days a week.
- Staff and patients told us diagnostic services were available 24 hours a day, seven days a week.

Medical care (including older people's care)

- Consultants were available on site during the day Monday to Friday and 9am to 3.30pm at weekends. There was an on-site registrar 24 hours a day, seven days a week.
- Physiotherapy services were available seven days a week.
- Pharmacy services were available 24 hours a day seven days a week.
- The integrated discharge team which was a multiagency approach to planned discharges worked seven days a week.
- The trust has a workforce and organisational development strategy 2015 – 2018. Two of the objectives were about ensuring that consultant job plans match service demand and support seven day delivery and to review the need for seven day services by clinical area and develop staffing models that match service demand.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessment and medical and nursing records.
- There were computers available on the wards we visited which gave staff access to patient and trust information Policies, protocols and procedures were kept on the trust's intranet which meant staff had access to them when required.
- Staff told us that some agency and bank nurses were unable to access the electronic patient recording system and this meant they were unable to access all the information about a patient they may be providing care for.
- On the majority of wards there were files containing minutes of meetings, ward protocols and audits which were available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff knowledge about the key principles of the Mental Capacity Act (2005) and how these applied to patient care was variable.
- Information provided by the trust showed that only 14% of staff in medical services trust wide had completed mental capacity act level 2 training and 7% had completed level 3 training. Mental capacity act training level 1 was incorporated within level 1 safeguarding training.
- Staff told us that it was doctors who carried out more formal capacity assessments for consent to treatment. We saw that these were recorded in four records of patients who lacked capacity on the endoscopy unit and ward 23.
- Staff had knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards (DoLs). DoLs are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. This includes people who may lack capacity. We saw an example of DoLs paperwork completed fully and accurately.
- Staff were not always following the key principles when using bed rails for patients. Staff we spoke to at all levels did not know that the use of bed rails are seen as a form of restraint in the national medical council code of practice. The trust policy for behaviour management and the use of restraint does mention that bedrails are a form of mechanical restraint but offers no further guidance for staff. The trust policy for slips, trips and falls, outlines what staff should do when using bedrails for those who lack capacity and this should be recorded. However, the bed rails assessment did not include the recording of consent or best interest decisions for the use of bed rails.
- Between April 2014 and April 2015 there had been 90 DoLs applications in medical services which is a significant increase from the previous year where only 10 applications were made. This showed that staff had an increased awareness and understanding of DoLs.
- On ward 14 the consent for a procedure had not been documented in a patient record we reviewed.

Are medical care services caring?

Good

Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with people were person-centred; however, there was limited interaction

with patients on ward 24 during our visit. People we spoke with during the inspection were complimentary about the staff that cared for them. Patients received compassionate care and their privacy and dignity was maintained

Patients were involved in their care, but were not always provided with appropriate emotional support.

Compassionate care

- Medical services were delivered by, caring and compassionate staff. We observed staff treating patients with dignity and respect
- We spoke to 22 patients throughout our inspection. All the patients we spoke with were positive about their care and treatment. Comments included 'staff have been brilliant', 'wonderful treatment' and 'treated with respect'. Patients said that staff always introduced themselves.
- As part of the unannounced visit on ward 24, we saw a patient whose nightclothes were raised above their hips. They were exposed in a manner that did not maintain their dignity and they told us that they had soiled themselves. There were no staff in the bay area to attend to her needs. We raised this immediately with staff who came to see the patient.
- We observed that during our time on the ward there was limited interaction between the patients and staff and patients were either in bed or sitting by their bed with no activity taking place. There was a television in each bay but these were turned off.
- The friends and family test (FFT) average response rate was 32% which was lower than the England average of 36%. The friends and family test asks patients how likely they are to recommend a hospital after treatment. The lowest response rate was ward 26 with 17% and the highest response rate was the medical assessment unit with 49%. 85% of patients said they would recommend medical services at the trust.
- In the cancer patient experience survey for inpatient stay 2013/2014, the trust performed in the top 20% of all trusts for 19 of the 34 areas. These included 'patient given the choice of different types of treatment, 'staff explained how operation had gone in understandable way' and 'nurses did not talk in front of them as if they were not there'. The trust fell in the bottom 20% of trusts for 'staff gave complete explanation of what would be done and 'family definitely given all information needed to help care at home' We saw that people had access to call bells and staff responded promptly. However, on the short stay medical unit a patient told us that they had not been shown how to use the call bell.
- The trust was performing better than the England average in all four parts of the patient-led assessments of the care environment (PLACE). These were cleanliness, food, privacy, dignity and wellbeing and facilities.
- The trust performed about the same as similar trusts in all areas of the 2014 CQC inpatient survey.

Understanding and involvement of patients and those close to them

- Patients all had a named nurse and consultant. Patients were aware of this and on the wards we visited; they were displayed on a board above the bed. However, on the medical short stay ward there was only a bed number above the bed. Staff told us this was to maintain patient confidentiality.
- Patients said that they had been involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.
- Patients said that they felt safe on the ward and had been orientated to the ward area on admission.
- Family members said that they were kept well informed about how their relative was progressing.
- Patients we spoke with said they had received good information about their condition and treatment. However, a patient told us that no one had explained why their heart monitor was 'alarming' and this distressed them.

Emotional support

- Some staff felt they had sufficient time to spend with patients when they needed support, but other staff felt that time pressures and workloads meant that this did not always happen.
- We received information from patients and those close to them before the inspection at listening events and through share your experience forms. This told us that staff did not always have the time to offer support to patients and were often left for long periods of time.
- Visiting times for the wards met the needs of the friends/relatives we spoke to. Open visiting times were available if patients needed support from their relatives.

Medical care (including older people's care)

- Patients and those close to them told us that clinical staff were approachable and they were able to talk to them if they needed to.
- Chaplaincy services were available for patients and relatives if required

Are medical care services responsive?

Requires improvement

There were a large number of patients being cared for in non-speciality beds and clear procedures or policies were not in place to help manage care for these patients. In addition, a significant number of patients experienced one or more ward moves during their admission, with 4% experiencing three ward moves and 1% experiencing four or more ward moves. The trust did not monitor the reason for moving patients between wards and could therefore not clarify whether the moves were made for clinical reasons.

Patients experienced a longer (worse) length of stay than the England average and there were significant numbers of people who were experiencing delayed discharge because they were waiting for packages of care and could not be discharged by the hospital until funding had been agreed for this care. At the time of our inspection there were 61 delayed discharges across all specialities. This meant that there were 61 people in hospital that didn't need to be.

The trust was working with other organisations in the community to develop new models of care and there were ambulatory services in place which aimed to prevent unnecessary readmission to hospital. There were specialist nurses who provided support and advice to staff and the service was mostly meeting individual needs for patients who had dementia or a learning disability.

Service planning and delivery to meet the needs of local people

- The trust was working with health partners in the locality, leading one of the vanguard sites across the country to develop a new healthcare model bringing GPs, community services, mental health and hospital services closer together to re-shape how services are provided. Vanguard means to lead the way in new developments or ideas.
- Consultant geriatricians provide a GP advice line Monday to Friday 9am– 5pm.
- Medical services had a designated ambulatory care unit. This unit saw patients on an outpatient basis for further tests or follow up assessments to avoid unnecessary admission or a longer stay in hospital. The service saw between one to thirteen patients a day.
- The facilities and premises in medical care services were appropriate for the services that were planned and delivered.

Access and flow

- Length of stay, delayed transfers of care and discharges had an impact on the flow of patients throughout the hospital due to the demand for medical services.
- Between April 2015 and July 2015 bed occupancy across medical services at the trust was consistently above 90%. Evidence shows when bed occupancy rises above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital. We looked at information provided by the trust and saw that bed occupancy rates on the medical wards were consistently high.
- Senior staff told us that they had recently employed a member of staff who was skilled in transformation changes and are looking at ways to reduce the bed occupancy to below 90% but this will take time.
- The average length of stay for medical care was above the national average for haematology at 12.9 days, which was worse than the England average of 5.2 days and respiratory medicine was 4.3 days, which was worse than the England average of 3.5 days. These were attributed to issues relating to accessing care packages, care facilities in the community and the large geographical area covered by the trust. These care issues resulted in delayed discharges.
- At the time of our inspection there were 61 delayed discharges across all specialities. This meant that there were 61 people in hospital that didn't need to be.
- There was a multidisciplinary integrated discharge team to support the discharge of patients across the trust. This team worked seven days a week. The team had trialled a different approach to discharges and also piloted designated discharge co-ordinators to individual wards. Staff told us that both projects had been evaluated but they were not aware of the outcome even though they had been involved in the projects.

Medical care (including older people's care)

- There was a focus on discharge planning for patients and wards. Staff discussed discharges at the daily board round and at the bed management meeting. Discharge letters were sent to general practitioners and the patient also received a copy.
- The trust was working with community services to increase the number of transitional beds from 40 to 70 whilst patients wait for their preferred care home. Staff said that from October 2015 there will be a fortnightly discharge planning group to look at best practice around discharges. This group will include community colleagues and social services.
- The medical short stay ward (MSSW) was a medical area, ideally used to provide care for patients up to five days. Patients should then be moved to the most appropriate ward to have their medical needs met. Staff told us the average length of stay on the unit was about seven days. At the time of our inspection there was a patient who had been on the MSSW for seven days waiting for a suitable bed on a speciality ward
- In addition there was a 16 seated chaired area which provided care for patients who were referred from A&E, GP's or the out of hours service 24 hours a day. Patients would then be assessed and if a bed was required, they would be allocated a medical bed on the wards. Staff told us that due to staffing shortages the chaired area would be often closed on average five days out of seven. This area was closed at the time of our inspection due to lack of staff. This meant that referred patients would be transferred to the emergency department for assessments. Staff on the MSSW told us that bed capacity and flow issues throughout the hospital impacted on their ability to appropriately transfer patients to other wards. This had a knock on effect on whether the unit were able to accept patients from the emergency department.
- Staff said that there was an internal target of four hours for patients admitted to the chaired area to be seen, discharged or moved to a bed. This information was put on the electronic patient record but the trust did not monitor performance against this target.
- The trust had a discharge lounge which operated between the hours of 8am and 8pm seven days a week. Staff said that patients could be waiting between 30 minutes and eight hours for discharge. We observed throughout our inspection that the average waiting time to be 35 minutes. On looking at previous records the longest wait for the previous week was 90 minutes. The co-ordinator told us that the number of discharges varied between 20-56 patients a day.
- From April 2014 to April 2015, 57% of patients experienced one or more ward moves during their admission. This was an increase from 47% the previous year. These results show that half of patients admitted to medical services at the trust were not treated in the correct speciality ward for the entirety of their stay. In addition, data supplied by the trust showed that for the same period, 1,589 patients (4% of admissions) had experience three or more ward moves and 590 patients (1%) had experienced four or more ward moves. The trust did not monitor the reason for moving patients between wards and could therefore not clarify whether the moves were made for clinical reasons.
- Referral to treatment times (RTT) for all medical specialities including cardiology, gastroenterology and neurology were mostly in line with the England average and general medicine was 100% compliant with 18 weeks RTT.
- Information provided by the trust showed that there was a shortage of medical beds and a number of patients placed on wards that were not best suited to meet their needs (also known as outliers). Between November 2014 and August 2015 data showed that there had been 1,203 medical outliers at the hospital, which is an average of approximately four patients a day. However, at the time of our inspection, there were no medical outliers. From talking to senior management staff it was unclear how the data had been collected.
- Patients who were outliers were reviewed on a daily basis by a member of the medical team and there was an appointed junior doctor to wards that were used for medical outliers.
- Information provided by the trust showed that the surgical assessment unit should not be used for medical outliers; however this had been used for medical patients consistently between November 2014 and September 2015.
- Staff told us there was no specific standard operating procedure or policy for outliers. We reviewed the trust escalation policy which did give some broad outline of how to manage outlying patients but was limited in the information. This meant that there was a risk these patients were not being managed effectively.

- The hospital held bed management meetings regularly throughout the day during the week to review and plan bed capacity and respond to acute bed availability pressures.

Meeting people's individual needs

- The trust used a yellow circle symbol to indicate that a patient was at risk of falls. This alerted staff to look at the risk assessment and care plan to ensure that any reasonable adjustments were made. However, when we asked a nurse what was the symbol used to indicate a risk of falls, they were unable to tell us and had to be prompted by the ward clerk.
- There was a specialist nurse for older people, who was the clinical lead for dementia who provided support for staff and a central point for queries. The trust also had access to a psychiatric liaison team who saw and assessed appropriate patients with a cognitive impairment.
- The hospital had implemented the 'forget-me-not' sticker scheme. This was a discrete flower symbol used as visual reminder to staff that patients were living with dementia or were confused. This was to ensure that patients received appropriate care, reducing the stress for the patient and increasing safety.
- Ward 22 had been adapted to be a dementia friendly environment, including dementia friendly signage, paintwork and flooring. The ward had a reminiscence room which was decorated and resourced appropriately, with books, radios and furniture.
- The hospital had a 'memories café'. The café gave patients, their families and their carers the chance to share experiences in a relaxed and informal setting surrounded by sights and sounds from days gone by.
- The service has a dementia strategy covering four years from 2014 to 2018. It included thirty separate actions covering Joint Advisory Group (JAG) training, clinical leadership, support for carers, assessment and care planning, and a dementia-friendly environment.
- People living with a learning disability were supported when having an endoscopy. Staff told us how they made reasonable adjustments such as a quiet room or specific anaesthetic supported appointment, although JAG regulations limited relatives being with them during the procedure.
- We observed that on ward 16, they can accommodate family staying with people who have a learning disability.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access these services.
- Leaflets were available for patients about services and the care they were receiving. Staff knew how to access copies in an accessible format, for people living with dementia or learning disabilities, and in braille for patients who had a visual impairment.
- Care plans we saw were not always personalised to identify individual needs but did contain the necessary information to ensure that patients were not at risk.
- There was a nurse specialist for diabetes who offered specialist advice to staff caring for people with this condition.
- Nurse practitioners had been trained in swallow assessments for people who had had a stroke. The plan was for this to be rolled out across the trust but staff did not know when this would be.
- Medical services had access to a substance misuse support team seven days a week which offered support to staff caring for people that needed this support. This service also provided an outreach service for detox at home.

Learning from complaints and concerns

- Patients and those close to them knew how to raise concerns or make a complaint. The trust encouraged people who used services, those close to them or their representatives to provide feedback about their care.
- There were leaflets available on all the wards we visited that explained the complaints procedure and the Patient Advice and Liaison Service (PALS)
- Staff were aware of the trust's complaints system and how to advise patients and those close to them if they wanted to make a complaint.
- Senior staff told us how they were now working to achieve 'on the spot' resolutions of concerns where possible.
- Learning from individual complaints was disseminated via team meetings. An example of learning included changes to how staff in the endoscopy unit respond to patients expectations about pain management. Wards displayed the compliments they received on information boards.
- A PALS report for the trust, including medical services, showed a number of concerns raised going back to 2014 with the outcome not yet recorded. The report showed no evidence of analysis of trends or learning.

Medical care (including older people's care)

Are medical care services well-led?

Requires improvement

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

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

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

The majority of staff said they felt supported and said that morale in medical services had improved over the past six months.

Vision and strategy for this service

- The trust's vision was summarised as the PROUD approach of care, which stood for patient, respect, ownership, unity, dedication. Staff were aware of the vision and they were displayed on the notice boards.
- The Trust's strategic objectives were based on the vision and these objectives cascaded down to service and individual objectives for staff.
- Medical services had a five-year strategy for 2014 – 2019. This included objectives such as ensuring all wards deliver a friends and family test score of 90% and a reduction in the number of hospital acquired infections. It also outlined how the delivery of the 6C's would be implemented. The 6C's are core values for staff and they are caring, compassion, communication, courage, competence and commitment. Whilst the strategy outlined the plans there was no clear underpinning action plan with specific timeframes and responsibility. Staff we spoke to were aware of the trust strategy but not aware of the strategy in medical services.
- NHS staff survey results for 2014 showed that 69% of staff said they had clear planned goals and objectives. The response rate for the trust was 46% which was above the England average but below the response rate in 2013 of 60%.

Governance, risk management and quality measurement

- The risk register highlighted risks across medical services and actions were in place to address concerns for example failure to meet National Institute of Clinical Excellence (NICE) guidelines. However, we were not assured that risks were being managed appropriately as there were risks on the register since 2012 with actions still being completed and the actions did not always have target dates for completion even though risks were being reviewed on a regular basis.
- Senior staff knew that there was a risk register and ward managers were able to tell us what the key risks were for their area of responsibility.
- There was a clear governance reporting structure in medical services and the main divisional management performance meeting was held on a monthly basis. During the meeting a review of the risk register, incident, infection, audits, complaints and feedback from other meetings were undertaken. However, actions were identified but it was not clear who the lead was for the action and the date the action was to have been completed. There was limited learning discussed at the meetings with the emphasis being on timeframes and numbers.
- Staff were unable to tell us how their ward performance was monitored, though they were aware that data was collected and discussed at the ward sister's weekly meeting.
- Multidisciplinary team meetings were not held regularly on each medical ward. There was evidence on the medical short stay ward that regular team meeting took place and these were minuted and cascaded to staff via email. There was also a copy of the minutes in a file on the ward for staff to read.
- It was unclear from the information we were given how staffing figures were captured. Staff at all levels told us that the information was collected in a variety of ways as

one system was not able to capture all staffing information as well as staff moves from one ward to another. This meant there was a risk the overall information may not be correct at all times.
- Winter plans for 2015 had been put in place which included opening an additional two medical wards. Recruitment for these wards had begun. However, not all staff we spoke to were aware of these plans.

Leadership of service

- Staff reported there was clear visibility of members of the trust board throughout the service. Staff could explain the leadership structure within the trust and the executive team were accessible to staff.
- All nursing staff spoke highly of the ward managers as leaders and told us they received good support. We observed good working relationships within all teams.
- Doctors told us that senior medical staff were accessible and responsive and they received good leadership and support.
- There were a number of new ward managers and there was little evidence of formal training and support to ensure they had the leadership skills required for their new role.

Culture within the service

- The majority of staff said they felt supported and able to speak up if they had concerns. They said there had been an improvement in staff morale in the last six months.
- In the 2014 staff survey, 63% of staff at the trust said they were enthusiastic about their job and 43% looked forward to going to work. 85% of staff said that the trust acted fairly with regard to career progression, regardless of ethnic background, gender, religion, sexual orientation, disability or age.
- Staff said there was a positive culture around challenging decisions by other staff. For example a doctor stated that a patient was ready for discharge which a nurse did not feel was appropriate. This was reviewed again by a consultant who agreed that the patient needed to stay a little longer in hospital.
- The latest staff friends and family test results for 2014-15, show that 69% of staff would recommend the organisation as a place to be treated. 51% of staff would recommend the organisation as a place to work. There were 208 responses from a total of 5810 staff to these two questions.

Public engagement

- There was a limited approach to obtaining the views of people who use services and we saw no systems in place on the wards we visited other than the friends and family test.
- This hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. 85% of patients would recommend medical services at the hospital to friends or a relative.

Staff engagement

- The trust celebrated the achievements of staff at an annual event. At the last event medical services had had a number of staff nominated for their work at the trust.
- The trust held regular 'listening into action' sessions for staff to engage with senior executive staff to discuss any issues or ideas. Medical services also held 'matron surgeries' for staff to talk to the matrons about any issues.
- Staff participated in the 2014 staff survey. This included how staff felt about the organisation and their personal development. 60% off staff at the trust felt the training and development they had undertaken had helped them to deliver a better patient experience and 64% felt it had helped them to do the job more effectively. 59% felt that they were valued by managers. This was about the same as the national average of 63%. The response rate was 46%, slightly higher than the National average of 42%.
- The trust had put in place an action plan to improve staff survey results for 2015.

Innovation, improvement and sustainability

- An analysis of the 2014 staff survey results showed 64% of staff at the trust, who responded, felt they were able to make suggestions to improve the work of their team/ department. This was worse than the national average of 74%
- The survey also showed that 64% of staff said they had frequent opportunities to show initiative in their role. 42% of staff said they were involved in deciding on changes to improve services for patients. This was worse than the national average of 53%.

Medical care (including older people's care)

- Medical services were planning to install electronic patient information whiteboards before the end of the year with the aim of enabling the service to see the patient flow from admission to discharge.
- We saw that on ward 33 the ward manager was implementing a monthly newsletter for staff which included safety incidents, alerts as well as good news and new ways of working.

Surgery

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

Information about the service

Arrowe Park Hospital carries out a range of emergency and planned surgical services including urology, ophthalmology, orthopaedics and general surgery. There are ten surgical wards and 25 theatres including designated ophthalmology and paediatric theatres that carry out emergency and elective procedures; including day case.

Data provided showed that 28,457 patients were admitted for surgical care between January 2014 and December 2014 at Arrowe Park Hospital. Of those, 46% were day case procedures, 15% were elective (planned) surgery and 38% were for emergency surgery.

As part of the inspection we visited the main theatre areas, including the recovery area, five inpatient surgical wards and observed parts of three operations. We observed one scheduled theatre staff meeting and a nursing and a medical handover.

We spoke with 18 patients, observed care and treatment and tracked one patients care from their admission to surgery. We reviewed 16 care records and spoke with a range of staff of different grades and specialities including nurses, doctors, ward managers, a clinical director, a divisional director and matrons.

Summary of findings

We found that Arrowe Park Hospital was delivering good surgical services to patients but some areas of the service, particularly those related to safety, required improvement.

Care and treatment was provided in line with national and best practice guidance. Regular audits were undertaken on regular basis.

Patients received care and treatment from competent staff who worked well as part of a multidisciplinary team. Staff sought appropriate consent from patients before delivering treatment and care. Most patients had a positive outcome as a result of being treated within surgical services.

Patients were treated with kindness, dignity and compassion and their relatives were involved in their care and treatment.

There were low rates of avoidable harm including infections and pressure ulcers. Staff completed risk assessments fully and implemented measures to minimise risk to patients. Records were completed correctly and legibly and the majority of staff were up to date with their mandatory training.

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

Surgery

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

Surgical services were responsive to patients needs and took into account the needs of the local population. The service managed complaints well and we saw evidence that learning from complaints took place.

Surgical services were well managed. Staff were aware of the trust's vision and were able to tell us how they contributed to it in their daily, working lives. Managers and leaders were visible and known to staff. Staff felt able to able approach them and raise concerns.

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

However, there were some areas for improvement:

Staff did not receive training on how to use the incident reporting system and told us they did not always report incidents as a result. When incidents were reported, feedback was not consistently given.

Nurse staffing levels were sufficient on the surgical wards and in theatre areas. However, nurse staffing levels within theatre recovery were observed to be insufficient at times. As a result, anaesthetic staff stayed to observe patients which could have an impact should they be required in theatre.

Managers considered the skill mix of staff and had taken appropriate action, to ensure that the surgical wards had suitably qualified staff to care for patients. However, in the recovery and theatre areas, we found that most staff had not undertaken paediatric life support despite regularly caring for children. There were a number of shifts identified through review of staffing rotas which had no paediatric life support trained nurses on duty.

Are surgery services safe?

Requires improvement

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

Nurse staffing levels were sufficient on the surgical wards and in theatre areas. However, nurse staffing levels within theatre recovery were observed to be insufficient at times. As a result, anaesthetic staff stayed to observe patients which could have an impact should they be required in theatre.

We found that most staff in theatre recovery areas had not undertaken paediatric life support despite regularly caring for children. A review of staffing rotas showed there were a number of shifts which had no paediatric life support trained nurses on duty.

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

Medical staffing was adequate and patients had access to suitably qualified doctors when required. Staff were aware of the trust's major incident policy and were able to show us a folder which contained details on what staff were to do in the event of a major incident.

93.5% of staff had completed their mandatory training and were aware of how to raise and manage safeguarding issues.

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

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

Incidents

- Staff understanding in relation to incident reporting within surgical services varied.

- Staff reported 376 incidents across the trust within surgical services between February 2015 and June 2015.
- There was an electronic incident reporting system in place which was available to all staff. When staff did report incidents, managers reviewed them and took appropriate responsive actions. Staff told us they did not receive feedback from incidents that they had raised but did receive general themes and lessons learned from incidents.
- Staff were aware of the types of incident they should report and were able to give us examples such as pressure ulcers and patient falls. However, we found one example where a patient had encountered a delay in receiving timely treatment. As a result of this, reporting of their diagnostic scan was delayed. Ward and medical staff had not identified or reported this incident and the patient was not informed of the delay.
- The trust did not stipulate that training on how to use the incident reporting system was mandatory. One member of staff had received training on how to use the incident reporting system and most staff told us that the system was easy to use. However, some staff told us that they did not feel comfortable using the system. Two clinical support workers said they did not use the system or report incidents as they did not know how to.
- Two members of staff also told us that they thought they needed an email address to fill out an incident form and as they did not have one, they did not report incidents. Senior managers confirmed that an email address was not required to use the incident reporting system but acknowledged that some staff still held this belief.
- There were three never events reported in surgical services at Arrowe Park Hospital between January 2014 and March 2015. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures are in place. In response to these incidents, the trust commissioned an independent review. An action plan was in place, which included key areas for improvement and intervention.
- The information provided by the service showed that two of the three never event incidents related to wrong side implant knee replacements. We observed two operations in theatres and saw that staff were following the steps required by the World Health Organization (WHO) surgical safety checklist. There were clear processes in place for staff to follow before during and after joint replacement surgery. Staff followed these processes fully, reducing the risk of surgical team inserting a wrong implant.
- Between May 2014 and June 2015, 13 serious incidents had been reported for surgical services at Arrowe Park Hospital. Serious incidents were investigated using a root cause analysis approach. We reviewed a sample of three investigation reports which showed that actions had been identified and put in place to prevent recurrence. We also saw evidence that the service had exercised its duty of candour in serious incident investigations.
- Staff told us they felt positive about being involved in the root cause analysis investigation process and that it was constructive not punitive.
- Staff were able to tell us of recent examples where they had improved their practice because of an investigation. One example given was regarding an error in the administration of a blood product. As a result of this incident a standard operating procedure had been introduced for staff to follow and extra training was provided. Staff told us that this had improved their confidence and reduced the risk of the error happening again.
- Staff gave examples of occasions when they had told patients that something had not gone as planned. For example, staff told us a patient had not had any food or drinks in preparation for surgery for a number of hours in error, they informed the patient immediately of the error, apologised and notified the patient of how to make a complaint if they wished.
- Managers shared lessons learned from incidents with frontline staff through newsletters, communications on notice boards and staff meetings.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots venous thromboembolism (VTE), was monitored on a monthly basis.
- Surgical services recorded and monitored data in line with this initiative. Ward areas displayed the information for staff and members of the public to view.

- Safety Thermometer information between June 2014 and June 2015 showed that surgical services performed within the expected range for falls with harm, catheter urinary tract infections and pressure ulcers. The data also showed there had been an overall improvement in the rate of pressure ulcers and catheter urinary tract infections since June 2014 and the rates of falls had remained similar for the same period.

Mandatory training

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

Safeguarding

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

Cleanliness, infection control and hygiene

- Surgical services effectively managed cleanliness, infection control and hygiene. Rates of infections were low and staff followed measures to protect patients from infections**.**
- There had been no cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia infections identified between March 2015 and August 2015. However, there had been two clostridium difficile infections in the same period at Arrowe Park Hospital. Investigations were completed in both cases to identify the root cause and actions were identified to reduce the risk of future infections.
- The ward and theatre areas we inspected were visibly clean and well maintained.
- Staff were aware of current infection prevention and control guidelines, and were able to give us examples of how they would apply these principles.
- Cleaning schedules were in place, with allocated responsibilities for cleaning the environment and decontaminating equipment.
- There was adequate access to hand washing sinks and hand gels.
- Staff were observed using personal protective equipment, such as gloves and aprons and changing this equipment between patient contacts. We saw staff washing their hands using the appropriate techniques and all staff followed the 'bare below the elbow' guidance. Staff followed procedures for gowning and scrubbing in the theatre areas.
- Patients with an infection were isolated in side rooms where possible. Staff identified the rooms with signs and information about control measures were clearly displayed. Staff told us when side rooms were not available, staff grouped patients with the same type of infection and they were placed in cohort bays. We observed that these bays displayed appropriate signage and staff used separate equipment from the main ward areas in these bays.
- The service undertook early screening for infections including MRSA during patient admissions and preoperative assessments. This meant that staff could identify and isolate patients early to help prevent the spread of infections.

Environment and equipment

- Equipment on the wards and in theatre areas was generally visibly clean, and well maintained. However, we observed a tourniquet machine in one operating theatre (a machine that applies pressure to patient's limbs) that had spots of rust visible. This machine was used in the sterile environment of theatres and therefore the rust damage could have posed a potential

risk of infection and affected how well the machine worked. We escalated this to senior managers within surgical services who assured us that they would arrange the replacement of this piece of equipment.
- Staff in the theatre and ward areas told us they had access to the equipment and instruments they needed to care for patients.
- Records indicated that staff carried out regular checks on key pieces of equipment. Emergency resuscitation equipment was in place and records indicated that it had been checked daily, with a more detailed check carried out weekly as per the hospital policy.
- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Bariatric equipment used for obese patients was readily available.
- There was a lack of thermometers in the theatre recovery area with staff having to share two thermometers between 11 patients.

Medicines

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

Records

- We reviewed 16 care records and found that individual care records were clear, legible and up to date. They contained detailed patient information, pre-operative assessments and progress records.
- The service and trust used electronic, computer based patient records. All nursing and medical staff within surgical services could access these records from laptop computers and tablet devices. This enabled remote monitoring of patient information for staff groups. We observed a surgical matron remotely reviewing patient risk assessment information and patient observations which enabled them to provide advice and support. In the event that nursing staff had a concern about a patient's condition, medical staff could review the patient's records and vital signs from any area in the hospital and provide advice before they arrived on the ward.
- We observed matrons checking the quality of records in the ward areas and highlighting any areas of concern with staff.

Assessing and responding to patient risk

- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and delays in obtaining beds for patients in theatre. Ward managers, matrons and senior managers in surgical services were visible and involved with addressing these risks on a daily basis.

- On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of specific harm such as venous thromboembolism (VTE), pressure ulcers, risk of falls and risk of infection. If staff identified patients susceptible to these risks, they placed patients on the relevant care pathway and treatment plans.
- An early warning score (EWS) system was in use in all areas of surgical services. The EWS system was used to monitor a patient's vital signs and identify patients at risk of deterioration. Staff carried out monitoring in response to patients' individual needs to identify any changes in their condition quickly. We saw examples of staff seeking appropriate help when a patient's condition deteriorated.
- We observed three operations and saw the theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The WHO checklist is an international tool developed to help prevent the risk of avoidable harm and errors before during and after surgery. Theatre staff completed safety checks before, during and after surgery and displayed a good understanding of the 'five steps to safer surgery' procedures. The WHO checklist had also been adapted for different theatre areas including ophthalmology theatres. We reviewed four WHO surgical checklists and these were fully completed.
- Two matrons told us that they had adopted a two-stage audit of compliance with the WHO checklist. Stage one was to review the records and stage two involved the auditor watching the WHO checklist and five steps to safer surgery being used live in the theatres. The results of this audit showed that compliance was consistently 99% and above.

Nurse staffing

- The staffing on surgical ward areas and in theatre areas was generally sufficient, with some periods of reduced staffing in areas because of last minute sickness and unexpected events. Regular staffing meetings were held within surgical services, where ward managers and senior managers assessed staffing across the service and moved staff where appropriate to mitigate risk. When moving staff was not possible, managers had attempted to reduce the risks associated with this by utilising bank and agency staff, ward staff undertaking extra shifts and matrons working in a clinical capacity.
- We reviewed three months of rotas for the surgical ward and theatre areas which showed that staffing levels were within recommended guidelines for most shifts. On the shifts where the staffing figures fell below recommended guidelines; this was due to short term and last minute absence. Managers had responded appropriately to try to address these staffing deficits.
- There was evidence that managers planned staffing while taking into account the skill mix and competencies of the staff on duty on the surgical wards with the exception of staff in the theatre and theatre recovery areas. An example of this was a lack of staff trained in paediatric life support on duty in theatre areas. This training was not mandatory for staff, despite the fact that staff frequently worked with children who had the potential to become clinically unstable following anaesthetic. Only nine members of staff out of 148 staff had received this training. We reviewed one month of rotas for theatre recovery areas and during this month, there were six shifts where none of the staff on duty had undertaken paediatric life support training.
- We observed the recovery area in theatres for a two-hour period. Staff were observed to be very busy and as a result, there was a delay in staff taking their meal breaks. At one point for a period of 20 minutes, we observed six patients within the recovery area. Four patients required close observation (observed every 5-10 minutes) and two patients required constant observation (a nurse or doctor staying with them at all times). However, we found there were not enough nursing staff to meet this need. As a result, two anaesthetists provided constant observation to two patients preventing them from going to theatre. Both medical and nursing staff told us that this was a frequent occurrence and happened at least once a week. We saw no evidence of these delays being monitored or reviewed. This could also lead to delays in theatres if anaesthetists are unable to return when required.
- During this busy period, we also observed staff caring for a child next to adult patients of mixed genders and the curtains were not drawn around their bed space. Staff told us they did not close the curtains as they were looking after multiple patients, they were very busy and needed to observe the child.
- Each clinical area openly displayed the expected and actual staffing levels on a notice board and staff

updated them on a daily basis. The staffing numbers displayed on the boards were correct at the time of the inspection and reflected the actual staffing numbers in all areas.
- We observed one nursing staff handover which was comprehensive and well structured. Safety information was handed over as part of this so that staff were aware of any issues which could affect patient safety.
- The vacancy rate for nurses in surgical services was below 3% for the five month period prior to the inspection. At the time of the inspection the vacancy rate for nurses across surgical services trust-wide was 2.4%.
- There was no acuity tool in use to assess and establish the number of staff needed on an ongoing basis within the theatre recovery area.

Medical staffing

- There were sufficient numbers of suitably qualified medical staff within surgical services.
- Junior and middle grade doctors told us that they were well supported by their seniors and consultants and were able to access senior advice and support, as they needed.
- There was sufficient medical cover available 24 hours a day, including outside of normal working hours when consultants were on call should they be required.
- Nursing staff told us that they were able to access 24-hour medical assistance and advice easily. We saw evidence that patients were seen promptly when medical review was requested and within 30 minutes if the review was deemed urgent.
- The medical skill mix was sufficient when compared with the England average. Consultants made up 45% of the medical workforce across the trust which was higher than the England average of 41%. The number of junior doctors within surgical services across the trust was 16% which was higher than the England average of 12%. However, there were less middle grade doctors and registrars at 38% when compared with the England average of 48%.
- Consultants and registrars led ward rounds consistently on a twice-daily basis. We observed one ward round on an acute surgical ward and saw that medical staff undertook the ward round effectively with appropriate communication with other disciplines and patients themselves.
- We observed one medical handover which was comprehensive and well structured. Medical staff were informed of important issues or patients who were at risk of deteriorating.

Major incident awareness and training

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

Are surgery services effective?

Good

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

Surgical services participated in national and local clinical audits and performed within or above (better than) the England average for most clinical performance measures. Where these standards were not achieved, the service had developed an action plan to improve.

Policies and procedures reflected national guidelines and best practice. Staff managed patients' nutritional and hydration needs well in all areas with the exception of the theatre recovery area, where hot drinks and hot food were not readily available for patients.

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

Evidence based care and treatment

- Patients received care and treatment in line with evidence based practice and national guidelines. Clinical audits included monitoring compliance with National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines.

- Staff on the surgical wards used care and recovery pathways and plans, in line with national guidance. We reviewed 12 patient care plans and saw that these were fully completed in all cases and staff updated them appropriately.
- Policies and procedures reflected current national guidelines and were easily accessible via the trust's intranet site.
- Staff completed venous thrombo-embolism (VTE) assessments for patients where appropriate and discussed options with them to reduce the risk of developing VTE following surgery.

Nutrition and hydration

- Staff managed the nutrition and hydration needs of patient's well, both pre and post operatively. Patients were given information in the form of leaflets about their surgery and told how long they would need to fast pre-operatively.
- On the surgical wards, a coloured tray system was in place so that staff could easily identify patients who required assistance with eating and drinking at mealtimes. Staff also placed symbols on the wards' patient information boards to identify patients who required assistance with eating and drinking and patients who required a specialised diet.
- Each ward identified a mealtime coordinator at the beginning of each shift. This coordinator aimed to ensure the smooth running of mealtimes in the ward areas.
- In all the records we reviewed, a nutritional risk assessment had been completed and updated regularly. This helped identify patients at risk of malnutrition and adapt to any ongoing nutritional or hydration needs.
- Staff told us that they were able to access specialist dieticians easily. We observed a specialist dietician reviewing three patients on two surgical wards.
- Staff consistently completed charts used to record patients' fluid input and output and where appropriate staff escalated any concerns. We observed a nurse requesting a medical review for a patient who had a reduced urine output.
- On the emergency surgical assessment unit, senior staff had implemented a training programme for health care support workers in the completion of fluid input and output charts. The senior doctors on the unit told us that they had seen an improvement in the completion of these charts since the training and this had led to a reduction in patients becoming dehydrated.
- Patients told us that staff offered them a variety of food and drink and did not highlight any concerns about the food and drink provided.
- In the theatre recovery area, we observed that there was poor provision of hot food and drinks for patients who had to stay in the area for long periods. Staff confirmed that only cold packed lunches and cold drinks were available for patients in the recovery area.

Pain relief

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

Patient outcomes

- Surgical services participated in national and internal audits to monitor patient outcomes. Outcomes for patients receiving treatment in the service were mostly better than the England average.
- Surgical services participated in a number of national clinical audits including the national hip replacement audit, national bowel cancer audit and the national emergency laparotomy audit.
- The national hip fracture audit measures a set of outcomes for patients who have suffered a hip fracture and been admitted to hospital. The service performed better than the England average for five of the seven outcomes measured in the national hip fracture audit. These outcomes related to the number of patients admitted to orthopaedic care within four hours, having surgery on the day of admission, receiving a pre-operative assessment by a specialist doctor in elderly medicine, receiving a bone health medication assessment and receiving a falls risk assessment. The service performed worse in two of the seven outcomes measured; these outcomes were the number of patients

developing pressure ulcers and the total length of stay for patient who suffered a hip fracture. There was no action plan in place to address this at the time of the inspection.

- The national bowel cancer and national lung cancer audits measure a number of outcomes, which give an indication of how well patients with bowel and lung cancer are treated. The service performed better than the England average for all the indicators measured in both of these audits.
- The national emergency laparotomy audit (NELA) report from August 2014 showed that 14 out of the 28 standards were available at the Hospital. The audit highlighted that the hospital did not have a dedicated surgical assessment unit and did not have key policies related to the care of emergency general surgery patients. Senior managers had reviewed the findings of the audit and had addressed some of the issues. The hospital had a dedicated emergency surgical assessment unit in place at the time of the inspection. The service was also in the process of developing policies and pathways in response to the findings.
- Performance reported outcomes measures (PROMs) data between April 2014 and December 2014 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 slightly worse than the England average. This means that patients undergoing these procedures had a similar outcome or a slightly worse outcome compared to patients in other areas of England. There was no action plan in place to address this issue at the time of the inspection.
- Hospital episode statistics from January 2014 to November 2014 data showed the average length of stay for elective and non-elective patients across all specialties was similar to the England average, which meant that patients stayed in hospital on average the same length of time as would be expected when compared to similar organisations in England.
- Data on hospital episode statistics December 2013 to November 2014 showed the number of patients who were readmitted to this hospital after discharge following elective and non-elective surgery was similar to the England average for all specialties except urology and gastrointestinal surgery where readmission rates were slightly worse. One of the measures put in place to attempt to improve readmission rates in urology was the introduction of a urology consultant who ran daily clinics within the emergency surgical assessment unit. This helped reduce readmission rates by giving patients access to a specialist consultant on a daily basis rather than attending the emergency department or being readmitted to the ward unless absolutely necessary.
- In addition, the emergency surgical assessment unit had used a similar approach and had recently increased the number of surgical consultants on the unit to three from zero. These consultants worked on the unit daily ensuring that there was at least one consultant on duty every day of the week. Staff told us that this increased clinical presence and the support had helped reduce readmission and general admissions to the surgical wards. The clinicians would see patients, treat them on the unit and arrange outpatient treatment options before discharging them home.

Competent staff

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

Multi-disciplinary working

Surgery

- 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. These meetings and huddles involved staff from different disciplines including nursing, medical and support staff.
- The ward staff told us they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. Patient records showed there was routine input from nursing and medical staff and allied health professionals.
- Staff across the services told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists, social workers and diagnostic support. Medical staff told us that they often experienced delays in receiving reports from diagnostic imaging and this affected patient treatment times and outcomes. We reviewed a patient's record and found that there had been a four-week delay in the reporting of their scan result by the diagnostic imaging department. This scan result included important information that the medical team needed to progress the patients treatment, therefore this led to a delay in the patient receiving appropriate treatment. We asked that this be reported as an incident and the trust assured us that they would be investigating the matter.

Seven day services

- Acute and emergency surgical services were available seven days a week. Out of hours medical and anaesthetist cover was sufficient and nursing staff told us they felt well supported outside normal working hours.
- There was a 24-hour emergency service with dedicated theatres. This meant that any patients admitted out of hours or over the weekend could have emergency surgery if required.
- Elective surgery was carried out five days per week.
- Junior and middle grade doctors provided out of hours medical care to patients on the surgical wards. There was also on-call cover provided by consultant surgeons.
- At weekends, a consultant saw newly admitted patients, and the ward-based doctors saw existing patients on the surgical wards. We did see evidence in patient records that consultants saw some existing patients at weekends when required.
- Microbiology, imaging (e.g. x-rays and scans), physiotherapy and pharmacy support was available outside of normal working hours.
- Medical staff told us that they had adequate access to urgent imaging outside of normal working hours. This meant that patients could have scans and x-ray's urgently out of hours if required.

Access to information

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

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff sought appropriate consent from patients prior to undertaking any treatment or procedures.
- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to tell us clearly about how they sought informed verbal and written

consent before providing care or treatment. All patient records we looked at indicated that staff had sought and obtained verbal or written consent before treatment was delivered.

- Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- If a patient lacked the capacity to make their own decisions, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals appropriately. Staff were able to give us recent examples of how they had considered these issues when delivering patient care. One example was that staff in a theatre area had identified during a pre-operative assessment that a patient lacked capacity to consent to their treatment. They escalated this appropriately and obtained specialist advice that resulted in the patient having an advocate appointed on their behalf. Patient records showed evidence that staff carried out mental capacity assessments for patients who lacked capacity.
- Staff had awareness of what practices could be deemed as restraint and displayed an understanding of the deprivation of liberty safeguards and their application.
- A trust-wide safeguarding team provided support and guidance for staff in relation to any issues regarding mental capacity assessments and deprivation of liberties safeguards.

Are surgery services caring?

Good

Staff treated patients with kindness, dignity and respect in the hospital. Staff provided care to patients while maintaining their privacy, dignity and confidentiality. Patients spoke very positively about the way staff treated them. They told us they were involved in decisions about their care and were informed about their plans of care.

The NHS Friends and Family test showed that most patients were happy with the care they received in surgical services. Where this test identified areas for improvement, staff were able to tell us how they had improved the service and showed us recent surveys with improved scores.

Compassionate care

- Staff treated patient with kindness, dignity, respect and compassion. Staff took time to interact with patients and communicated with patients in a considerate and compassionate manner.
- The areas we visited were compliant with same-sex accommodation guidelines. Patient's dignity was respected. We observed that curtains were closed around patient bed areas when staff were providing personal care. There were private areas available where staff could speak to patients privately if required, in order to maintain confidentiality.
- We spoke with 18 patients, who gave us positive feedback about how staff treated and interacted with them. They told us that staff went out of their way to ensure that they maintained patient's dignity.
- The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patient's satisfaction with the healthcare they have received. The results between August 2014 and February 2015 showed that the majority of 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. One surgical ward scored consistently lower than the England average for this period; however, test data between June and September 2015 showed an improvement, with scores higher than the England average for this period.
- The matron and associate director of nursing for surgery told us that they had made changes to increase the response rate for the FFT, which were lower than the England average for six of the seven surgical wards. They told us that they discussed the FFT at team meetings, and prompted ward staff to encourage more patients to complete the test.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care and communicated with patients in a way they could understand.
- Patients and their families told us that staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them verbally and in the form of written materials, such as information leaflets specific to their condition and treatment.

Surgery

- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions.
- Staff identified when patients required additional support to be involved in their care and treatment, including translation services. Staff were able to tell us how they would access translation services including sign language interpreters.
- Medical ward rounds took place on a daily basis and included input from the nursing staff and other allied health professionals such as physiotherapists and social workers if needed. During these rounds we observed the medical team giving information to patients about their condition and treatment clearly and in a way they could understand.
- Pre-operative assessments took place and took into account individual preferences. We observed staff using the 'this is me' document during pre-operative assessments. Staff completed this document with patients and their families to understand the wishes and needs of patients living with a cognitive impairment, such as dementia.

Emotional support

- Staff demonstrated that they understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives.
- Patients told us that staff supported them with their emotional needs.
- We observed examples of staff supporting patients to maximise their independence. One example of this was pre-operative education for patients undergoing joint replacement surgery. As part of this pre-operative education program, staff were able to identify patients who required additional support in the post-operative phase of their treatment and ensure it was in place at the time of their post-operative discharge. This meant patients were able to be discharged as soon as possible after their operations and maintain their independence.

Are surgery services responsive?

Good

Surgical services were responsive to the needs of patients. They were well organised and had provisions in place to meet the needs of the local population. Staff kept patients well informed of their treatment and care. Information was readily available for patients in a variety of formats, which could be adapted to individual needs.

A consistently lower number of planned operations were cancelled between October 2013 and October 2015 than the England average.

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

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

There were some issues with access and flow within the theatre recovery area. Staff reported that patients sometimes had to stay in the area overnight due to bed shortages, which was not appropriate. Data showed that patients had timely access to consultant led care which met the national target of 90% most of the time.

Planning and delivering services which meet people's needs

- Surgical services were planned and delivered to meet the needs of patients and we noted that the service used data about the local population to inform their planning.
- A matron told us the service had adapted facilities to meet the needs of the changing local population as there had been an increase in the number of patients who were being admitted to surgical services with a cognitive impairment, such as dementia. Additional funding was obtained to develop a ward specifically for patients living with dementia. This included changing the layout of the area and the colour scheme to improve the experience and comfort for patients living with a cognitive impairment.
- The directorate manager for surgical services also told us how the senior management team had noted an increase in the number of patients who were suitable for day case surgery. Surgical services had therefore increased their capacity to provide day case surgery to meet this demand.
- Regular meetings were held to assess whether the service needed to change or adapt to new information about the local population.

- There was an emergency general surgery and trauma theatre that was staffed 24-hours, seven day per week so that operations could be performed for patients requiring emergency surgery at any time of the day.
- There was a dedicated paediatric theatre for children who required surgery, which was separated from the adult and obstetric theatres.

Meeting individual needs

- Information leaflets about services and treatments were readily available in all areas. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested and we saw examples of information leaflets in different languages available on the day case unit.
- Staff told us that they could access an interpreter for patients' whose first language was not English and were able to show us how they would do this. They also had access to language line which is a telephone translation facility.
- Staff received mandatory training in the care of patients living with dementia. Each ward area had a dementia link nurse in place and there were designated 'dementia friendly' wards and areas within surgical services. Staff could also contact a trust-wide safeguarding team for advice and support in treating with patients living with dementia or a learning disability.
- Staff used a 'this is me' document for patients admitted to the hospital with dementia. Patients or their representatives completed this document and included key information such as the patient's likes and dislikes. This document was also completed during the pre-operative stage of a patients care to ensure any reasonable adjustments which were needed were put in place.
- A reasonable adjustment pathway was in place for patients living with a disability and in use in all theatre areas. This pathway alerted staff to any reasonable adjustments that they needed to make. We saw evidence that this pathway had been used in patient records.
- We saw evidence of staff planning care for patients who identified as transgender in a way that would meet their needs. This planning included specifying what preferred name patients would like to be called and the gender they identified with. Staff told us they also gave them the option to be treated in a side room for privacy or in the main bay areas. Where possible, staff accommodated these preferences.
- Access to psychiatric support was readily available and staff told us they did not have any issues accessing this support for patients.
- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients who are clinically obese).
- The theatre recovery areas had designated paediatric theatre and recovery bays. Paediatric patients frequently had to be treated in the main theatre and recovery areas for emergency surgery.
- Accessibility to all facilities and areas was good with the exception of the emergency surgical assessment unit. The emergency surgical assessment unit had narrow corridors and furniture blocked key access routes to toilet facilities for patients with restricted mobility. The ward sister told us that there were plans to relocate the unit to more suitable premises in the near future.

Access and flow

- Patients were admitted for surgical treatment and care through a variety of routes, including pre-planned surgery, the emergency department and by GP referral.
- Patients admitted through the emergency department or by GP referral were directed to the emergency surgical assessment unit, which had 11 inpatient beds including four trolley spaces. The unit had an assessment bay and trolley area where patients waited for staff to assess them.
- The admission, transfer or discharge of patients from the surgical wards was well managed in all areas except the theatre recovery area.
- Staff in the theatre recovery areas told us they sometimes had difficulty transferring patients back to surgical wards after their operations and as a result, patients would stay in theatre recovery overnight due to lack of beds on surgical wards.
- Staff also told us they occasionally had to care for critically ill patients who required care on the intensive care unit because of lack of bed availability in the critical care areas. We reviewed the theatre recovery logbook, which detailed all patients who entered the recovery area. This book showed that in a three-month period four patients remained in theatre recovery

overnight due to lack of beds on surgical wards. A further two patients spent the night in the theatre recovery area awaiting a bed on the intensive care unit. The theatre recovery area is not equipped to keep patients for long periods. There are no private toilet facilities or provision of hot food and drinks.

- Staff within the theatre recovery areas told us that they did not feel suitably qualified or experienced to care for patients who were critically unwell and required extended periods of intensive care. Patients requiring critical and intensive care for prolonged periods are at a higher risk of deterioration and therefore are at a higher risk of requiring resuscitation or additional support. Training data provided by the service showed that only six staff within the recovery area had undertaken immediate life support.
- Patient records showed discharge planning took place at an early stage and there was multidisciplinary input (e.g. from physiotherapists and social workers). Staff completed a discharge checklist, which covered areas such as medication and communication. Discharge letters written by the doctors included all the relevant clinical information relating to the patient's stay at the hospital.
- Data showed that the overall hospital-wide bed occupancy rate between April 2015 and August 2015 was consistently below 85%. When bed occupancy rises above 85% it can start to affect the quality of care provided to patients. Ward managers and matrons monitored bed occupancy rates on a daily basis and patients were transferred to other surgical wards if no beds were available within a specific surgical specialty.
- Trust data showed that medical patients were regularly outlied to surgical wards (moved to a ward which is not best suited to meet their needs due to bed availability issues). Staff on the surgical wards told us that doctors regularly saw patients who were outlied from the medical specialties.
- In addition, the emergency surgical assessment unit was consistently used to house medical outliers. This was despite guidance within the trust stating that this unit should not be used for medical outliers. Staff on the emergency surgical assessment unit told us surgical patients sometimes experienced delays in accessing the assessment unit due to beds being filled with medical outliers.
- Data showed that the service was performing above the England average for the national 18 week referral to treatment target. However, the service narrowly missed the target of 90% in the urology and general surgery specialities, with urology performing at 88.2% and general surgery at 89.2%. This meant most patients referred to the surgical specialities started consultant led treatment within 18 weeks of being referred.
- The associate director for scheduled care told us performance against waiting time standards was routinely monitored and improvements were achieved through better planning and routine multidisciplinary meetings.
- NHS England data showed there was a significant improvement in the number of operations cancelled from October 2013 to March 2015, where the service had consistently performed better the England average. This meant that a lower number of patients had their planned operations cancelled in this service compared to other services of a similar size in England.
- Patients told us they had easy access to surgical services and had not experienced delays in accessing treatment.
- The average length of time that patients stayed in hospital after having surgical treatment was around the same as the England average. In some specialities the length of time patients stayed in hospital after surgical treatment was longer than the England average; notably in the urology and trauma and orthopaedic specialities. Senior managers told us they were working to reduce the length of time patients stayed in hospital following surgical treatment. One of the ways they were trying to do this was through the introduction of specialised treatment pathways and pre-operative preparation programmes for patients. The service hoped that by preparing patients as much as possible before planned surgery, this would help facilitate their discharge after surgery.

Learning from complaints and concerns

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- Patients told us they knew how to make a complaint. Posters were displayed around the hospital detailing how to make a complaint. Leaflets detailing how to make a complaint were readily available in all areas.
- Notice boards within the clinical areas included information including the number of complaints and any comments for improvement.

Surgery

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

Are surgery services well-led?

Good

Surgical services were well led at local and divisional level. The trusts vision was embedded throughout the division. Staff were clear what this vision was and were able to tell us how they contributed to it in their daily, working lives. There were robust governance frameworks within service and managers were clear about their roles and responsibilities.

Risks were appropriately identified, monitored and there was evidence of action taken where appropriate. There was clear leadership throughout the service and staff spoke positively about their managers and leaders. Senior managers were visible and known to staff and staff felt able to able approach them and raise concerns.

Staff told us the culture within the service had improved in particular in theatre areas as a result of an independent review. Senior managers and clinical leaders were open to challenges and willing to make changes to improve patient care.

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

Services vision and strategy

- The trust had a vision which is based around the PROUD values; patient, respect, ownership, unity and dedication. This vision was displayed prominently around the hospital on posters. Staff were aware of the vision and were able to articulate the vision and values for the trust. This vision was embedded in the trust and services strategies**.**

Governance, risk management and quality measurement

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

Leadership of this services

- The leadership within surgical services reflected the vision and values set out by the trust. Staff spoke positively about leaders within the services. Leaders were visible, respected and competent in their roles.

- There were clearly defined and visible leadership roles across surgical services. Staff told us that their managers and senior leaders were visible and approachable. Staff identified the clinical director, surgical services divisional director and associate director of nursing and told us they were frequently in the clinical areas and spoke with staff regularly. Staff particularly spoke positively of surgical services divisional director and told us the culture within the theatre area had improved since the appointment.
- Matrons for surgical services and the theatre manager were visible during our visit. Staff spoke positively of their matrons and the theatre manager.
- Staff told us the matrons often helped them with direct patient care when required. We observed matrons staying late and coming into work early to be available to speak with night staff.
- Medical staff told us their senior clinicians supported them well and they had access to senior clinicians when they required.

Culture within this services

- Staff we spoke with told us they felt respected and valued.
- A higher number of never events occurred between January 2014 and August 2014 in the theatre areas. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. This prompted the trust board to commission an external review into the culture within the theatre areas.
- The independent review highlighted significant areas for concern and improvement. These included a culture of not tackling bullying among staff members, fear among staff groups to 'speak up', low morale and disconnect between senior managers and frontline staff. The 2014 staff survey for the services also reflected this and showed that only 59% of staff employed would feel secure raising a concern about unsafe clinical practice compared to a national average of 80%.The trust and service responded positively to this report and its recommendations by formulating a robust action plan to address areas of concern. Senior managers had begun to implement appropriate actions. Some actions had not been completed at the time of the inspection, but there was evidence the action plan was updated and reviewed on a regular basis. Frontline staff told us what these actions were and displayed a good understanding of issues identified in this review. Senior managers and frontline staff were able to articulate what action they had taken because of the review.
- Staff told us that they felt more supported since the review and felt the culture within the theatre areas had changed for the better since the review. However, two staff from theatre areas felt there needed to be more support from senior managers.
- All staff told us they would now feel secure raising a concern or issue with their managers.

Public engagement

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

Staff engagement

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

Innovation, improvement and sustainability

- Staff and managers were continually striving to improve the care and treatment patients received.
- Staff told us they were able to suggest improvements to managers and they considered and implemented them where possible. One example of this was the suggestion by staff that the services needed dementia friendly areas, which are now in place in the hospital and a specialist unit is being developed for this patient group.
- Leaders were working to continually improve services. We saw evidence of this in the form of robust plans relating to improvements that assessed and ensured sustainability while ensuring patients were at the centre of the decisions made.

Surgery

- The emergency surgical assessment unit was innovative in its approach to patient care. The implementation of seven day designated emergency surgical consultants had improved patient care and the timeliness of their care.

Critical care

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

Information about the service

The critical care unit at Arrowe Park Hospital is a 18 bedded unit commissioned to provide care and treatment for eight level 3 and ten level 2 adult patients. In reality, this configuration changed according to demand and we saw that the unit was equipped to be able to take 18 level 3 patients if required.

The critical care unit is divided into two distinct clinical areas, a 12 bedded unit where the level 3 intensive care unit (ITU) patients are cared for and a separate six bedded level 2 high dependency unit (HDU). Both areas have two side rooms each for the purpose of isolating patients that present an increased infection control risk. A critical care outreach service is also provided. The outreach team are based within the critical care department and managed by the divisional matron.

According to the intensive care national audit and research centre (ICNARC) data for 2014, the units had 881 admissions and the service is a member of the Cheshire and Merseyside Critical Care Network (CMCCN). For the purposes of governance, critical care sits in the trust's medical and acute division.

As part of the inspection we visited the unit on 16 and 17 September 2015. We spoke with consultants, junior medical staff, 17 members of the nursing team, two allied health professionals, two members of support staff, one member of the housekeeping team, two patients and three sets of relatives. We also reviewed patient records, policies, guidance and audit documentation.

Summary of findings

We have judged that overall, the critical care service at Arrowe Park Hospital required improvement, more specifically in the areas of safety, responsiveness and leadership.

There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients. However, we found examples where incidents such as delayed discharges were not reported.

The clinical areas fell short of the most recent health building note specifications (HBN 04-02) in relation to bed space dimensions and infection control isolation rooms. Monitoring equipment and ventilators were seven years old and required replacement yet there was no clear plan in place to ensure capital funding was available to facilitate this. Transfer equipment for critically ill adults did not meet the current Intensive Care Society standard in that it could not be secured in an ambulance. Hand hygiene best practice was not being followed by all staff.

There was no clear, shared vision or strategy for the unit. The nursing structure on the unit meant that senior band 7 nurses were being managed on a day to day basis by a band 7 intra-unit nurse manager. This inevitably resulted in some tensions. There was a governance structure in place though at times it was unclear how risks were being, monitored, managed and reviewed.

Critical care

The unit continued to collect and submit data for the intensive care national audit and research centre (ICNARC) for validation, so it was able to benchmark its performance against comparable units. These data showed that apart from delayed and out of hours discharges, patient outcomes were within the expected ranges when compared with similar critical care units nationally.

We saw patients, their relatives and friends being treated with care, compassion, dignity and respect.

Are critical care services safe?

Requires improvement

Overall, we judged that the critical care services at Arrowe Park Hospital required improvement in terms of safety.

There was an inconsistency of understanding amongst staff regarding the threshold for reporting incidents, for example cases of delayed discharges from critical care which were not recorded as an incident.

The clinical area, whilst functional, was dated and had limited space and fell short of the most recent health building note specifications (HBN-04-02). Monitors and ventilators were seven years old and no longer covered by the manufacturer's maintenance contract.

Best practice in hand hygiene was not always being followed. During a period of 50 minutes observation we saw that not all staff either washed their hands or used antiseptic hand gel when moving between patients.

On occasions, delays in admission meant patients were cared for in theatre recovery and it could not be guaranteed that the theatre nurse or operating department practitioner or theatre recovery staff on duty had the necessary competencies to nurse a level 3 critical care patient.

Not all the medical and nursing records that we examined had entries that were dated and signed.

There was no protocol in place for the management and transfer of patients who deteriorated on the Clatterbridge Hospital site.

The latest peer review by the Cheshire and Merseyside Critical Care Network in March 2015 reported that there was no clear or robust contingency plan for business continuity if evacuation and relocation of the critical care service was required in an emergency.

Incidents

- The trust had a policy and electronic system for the reporting and management of incidents and related investigations.
- Staff were often vague or unclear when questioned about reporting incidents. For example, we received inconsistent answers to the question, 'are single sex

breaches reported as incidents'. Some staff reported that they hadn't used the incident reporting system in years. One view was expressed that low numbers of incidents being reported was positive.

- In an external report dated May 2015, comparing the rates of different patient safety incidents reported by other trusts who were members of the Cheshire and Merseyside Critical Care Network, the unit at Arrowe Park Hospital was the lowest reporter of all patient safety incidents associated with harm.
- A report from the trust incident reporting system for March to June 2015 showed that there had been 621 incidents reported from the acute care division with 53 reported from critical care. There had been no serious incidents reported for the period May 2014 to May 2015.
- We saw a separate incident record specifically for medication errors and incidents. In the period September 2014 to September 2015 there were 54 medicines related incidents reported in critical care. These were predominantly prescribing and administration errors. The records showed details of the incidents themselves and a summary of the actions taken.
- We found that when patients were discharged outside of normal working hours, it was not reported as an incident, which may limit the opportunity to learn and improve.
- Incidents that were reported were discussed in multi-disciplinary and nursing staff meetings in critical care. Staff told us that incidents and learning was also shared during the daily safety 'huddles' on the unit. There was a 'learning from experience' board in the staff room, which also included information about recent complaints and any associated learning.
- Mortality and morbidity meetings were held monthly and all mortalities were discussed. The minutes of the meetings included action points and highlighted learning opportunities.
- Staff had varying levels of understanding about duty of candour. We saw there had been a trust policy document about duty of candour circulated via the intranet in July 2015 but not all the staff had yet read it.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety thermometer data was submitted from the unit and reported at divisional level. This included data on patient falls, pressure ulcers, urinary catheter related infections and episodes of venous thromboembolism (VTE).
- For the six months from March 2015 to August 2015 there had been no reported falls, pressure ulcers or episodes of VTE in critical care. However, there had been two cases of catheter acquired urinary tract infections.

Cleanliness, infection control and hygiene

- Clinical areas, offices, corridors, store rooms and staff areas were visibly clean.
- The trust had infection prevention and control policies in place which were accessible to staff.
- Personal protective equipment was available for staff and we saw it being used appropriately. There were sufficient hand washing facilities and antiseptic gels available.
- As part of the inspection, we undertook a 50 minute period of observation to gain a better insight into infection control practice. More specifically we looked at hand hygiene practice, including hand washing and the use of antiseptic gels. We saw that not all staff followed 'bare below the elbows' guidance. We saw mixed levels of compliance with hand hygiene protocols. Nursing staff were observed to wash their hands and apply antiseptic gels between patients. This was not always the case with medical staff and allied health professionals.
- The most recently available and validated intensive care national audit and research centre (ICNARC) data showed that the unit was performing better than similar units for unit acquired methicillin resistant staphylococcus aureus (MRSA), clostridium difficile and infections in blood. In addition, the unit was performing better than similar units for the number of patients who tested positive for MRSA prior to admission or within 48 hours of admission. The unit was also comparable with similar units for the detection of clostridium difficile toxin in any stool sample taken prior to admission or within 48 hours of admission.
- For the period January to July 2015 there had been just one catheter related blood stream infection (CRBSI) recorded against 1626 cumulative line days. Cumulative line days refers to the total number of days in the period for which patients had intravenous catheters in situ.

Environment and equipment

Critical care

- The trust acknowledged, in the trust wide risk register, that the existing critical care unit footprint and bed layout were outdated and did not meet the latest guidance published by the Department of Health in 2013.
- Care and treatment was delivered in two separate areas, which made up the critical care unit; the 12 bedded intensive care unit (ITU), commissioned to provide care for eight level 3 patients and four at level 2; and the six bedded HDU area, used for level 2 patients. The ITU was cramped and unwelcoming with little natural light coming from high level windows. The double entrance doors to the unit opened right into a patient bed area which may affect that patient's privacy and dignity. The HDU area was brighter with more natural light but was still cramped and the isolation rooms did not meet current guidance. More specifically they did not have entrance lobbies, which are required for effective isolation of patients to control the spread of infection or to protect an immuno-suppressed patient.
- Monitors and ventilators were more than seven years old, which meant that the manufacturer service contracts were null and void. This was recorded as a risk and the mitigation recorded was that a business case for capital funding would be developed for new monitors and ventilators and presented to the board but this hadn't happened at the time of the inspection.
- Senior staff told us that there was never a problem replacing or securing new equipment. Staff told us that as well as monitors and ventilators, the unit needed replacement mattresses and beds. The unit had one turn assist bed. A turn assist bed could help staff better respond to the needs of immobile patients with a moderate to high risk of pressure ulcer development. The remainder of the beds on the unit were more basic.
- Equipment on the unit was managed and serviced by the unit's equipment technician in conjunction with the trust electro biomedical engineering (EBME) team. All equipment displayed a label indicating when it was last serviced and when the next service was due. Labels on all of the equipment we looked at indicated that the equipment had been serviced within the allotted time frames.
- We saw resuscitation equipment, including defibrillators and difficult airway management trolleys. Records indicated that these were all checked daily.
- The emergency transfer equipment did not meet the latest Intensive Care Society standard as it could not be secured in the ambulance.

Medicines

- There was a dedicated senior clinical pharmacist allocated to critical care for 0.9 whole time equivalent (WTE). The intensive care society pharmacy standards state that there should be at least 0.1 WTE for specialist clinical pharmacist for each level 3 bed and for two level 2 beds. This ratio indicates that, if all 18 beds were occupied as commissioned, the critical care unit would fall short of meeting the standard by 0.4 WTE.
- The critical care pharmacist attended the daily ward round and covered the unit Monday to Friday plus one weekend in seven. Out of hours pharmacy cover was provided on the remaining six weekends by a pool of pharmacists who had received critical care training.
- Medicines were stored safely and in a locked room. The controlled drugs were held securely. Records indicated they were checked and administered in accordance with the trust policy.
- The medicines storage room and drug fridge temperatures were monitored and recorded daily.
- The critical care unit used a different prescription chart to the rest of the hospital, so when patients were discharged to the wards, a new ward prescription chart was transcribed.

Records

- We looked closely at five sets of patient's bedside records. Some of the notes were contained in binders that were dirty and old.
- The paper records comprised a range of clinical records, assessments and plans. These included, for example, nutritional risk, falls assessments, physiotherapy treatment plans and skin bundles. All entries were completed, signed and dated although the legibility of handwritten notes varied.
- It was often difficult to follow clinical events. The most recent record wasn't always the first one meaning we had to search through them to find the most recent one and there was also duplication of some information from members of the multi-disciplinary team.
- Although entries in records were usually signed and dated, the authors name was not always printed alongside the signature.

- The second consultant review of the patient's condition was not always documented in the records.
- Physiological parameters were recorded by the nurse looking after the patient on a large chart located close to the bedside.

Safeguarding

- There was an internal system for raising safeguarding concerns and staff were aware of the process and could explain what constituted abuse and neglect.
- Safeguarding adults and children training was part of the trust mandatory training programme. Records showed that 100% of nursing and medical staff had completed safeguarding level 1 training. In terms of safeguarding level two, 82% of the medical staff and 55% of the nursing staff on critical care had completed the training. Safeguarding training was refreshed every three years.

Mandatory training

- Divisional records were held for mandatory training which was divided into two sections, block A and block B. Block A mandatory training was completed every 3 years and included fire safety, manual handling, health and safety (including incident reporting), risk management, infection prevention and control, medicines management, consent and the use of chaperones. Block B mandatory training was completed every 18 months and included a refresh on the same subjects though not in so much detail.
- The mandatory training completion records for critical care showed that for block A – 73% of medical staff, 96% of nursing staff and 93% of all other staff had completed the training. For block B – only 18% of medical staff, 56% of nursing staff and 86% of all other staff had completed the training. The training completion records did not indicate the target for critical care staff. The trust's target was for 95% of staff to have completed this training.

Assessing and responding to patient risk

- There were tools in place for the early detection and escalation of changes in a patient's condition. The hospital used a modified early warning system (MEWS). MEWS is a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically.
- Within the critical care service there was an outreach team, providing critical care outreach from 8am to 8pm seven days a week. There were three nurses in the outreach team all with critical care experience. Outside of these hours, the outreach cover was provided by the night hospital clinical co-ordinators.
- The outreach team saw all patients discharged from critical care within 24 hours and provided education and support for ward staff.
- Outreach performance was analysed and an annual report was produced. The figures for 2014 showed that the outreach team followed up 99.3% of all patients discharged from critical care and that the mean average number of repeat assessments after initial follow up was 4.1. This represents the average number of visits that a patient received from the outreach team following their discharge from critical care. Of the 645 follow up patients seen during this period, 58 were assessed as being at level 2.
- For the period January to December 2014 the outreach team received 1752 ward referrals (approximately 5 per day) and actually visited 97% of those patients. Of these patients 462 were assessed as being level 2 and 25 were at level 3. As well as the patient's parent team, the outreach team were able to refer patients to critical care. This meant that if the outreach team identified a deteriorating patient that required critical care then any delays in referral were minimised.
- There was no protocol in place for the management and transfer of patients who deteriorated on the Clatterbridge Hospital site.

Nursing staffing

- The Intensive Care Society patient acuity measure was being used to determine the number of staff required.
- At the time of the inspection, there were adequate numbers of suitably skilled and qualified nursing staff on duty to ensure that patients received safe care and treatment.
- There was a supernumerary (supernumerary means they were not included in the daily staffing numbers so that they could oversee the running of the unit and assist where necessary) shift co-ordinator on duty for both the intensive care unit (ITU) and high dependency unit (HDU).
- Staff rotated between both clinical areas and their allocation could vary day to day. For example, a band 5 nurse could be in the level 3 area (ITU) for one shift followed by a shift in the level 2 (HDU) area.

Critical care

- Nurses were supported to deliver care and treatment by both clinical and non-clinical support workers.
- On three occasions during the 12 months prior to the inspection, three level 3 patients were cared for in theatre recovery overnight as there were no appropriate critical care beds available. It could not be guaranteed that the theatre nurse, operating department practitioner or theatre recovery staff on duty had the necessary competencies to nurse a level 3 critical care patient. There was a written operational policy entitled 'Operational Framework for Critically Ill patients extra-ordinarily managed in Theatre Recovery' dated September 2015, which set out the medical and nursing responsibilities for managing such patients whilst they were in the recovery area. The framework document stated that the medical responsibility to guide the clinical care of the patient sat with the duty intensive care consultant but in practice this only happened once the patient had been 'accepted' by critical care team.
- The trust employed 1.5 whole time equivalent (WTE) critical care practice educators in post. These posts were used to co-ordinate the education, training and continuous professional development for critical care nurses. On the first day of the inspection, the practice educator was working a clinical shift, covering for staff sickness.
- There were 14 band 7 nurses on the staffing rota and the critical care unit manager was also a band 7.
- For the period March 2015 to August 2015, the number of WTE nurses in post had risen from 92.1 to 97.1 although the unit was still carrying a vacancy factor of 3.2% for trained nursing staff. Over the same time period the nursing staff turnover rate had fallen from 11.5% to 6.2%, meaning that more staff had been retained.
- There were two shift handovers per day and a separate sister to sister handover took place to include any non-clinical issues. The nursing staff handovers included a 'huddle'. Huddles are seen as a way of engaging all staff in daily safety and patient flow activity. Evidence has showed that effective huddles reduce the number of adverse events and lead to an increased number of morning discharges.
- Agency staff were occasionally used but only as a last resort as they had limited access to systems and their individual practice was limited. For example, they did not administer medication. Wherever possible vacant shifts were filled by existing staff or bank nurses.

Medical staffing

- The unit operated with a named consultant for the Monday morning at 8am through to Friday lunchtime, with a second consultant also on duty for the same period of time. The on-call consultant took over at 5pm. This arrangement provided some medical continuity of care.
- There were 12 intensive care consultants, which put them over their defined staffing establishment by 0.3 whole time equivalent (WTE). The turnover rate for medical staff in critical care was 0% for the period March to August 2015.
- Consultant to patient ratio was normally no more than the 1:8 which is in accordance with Intensive Care Society standards.
- There was a consultant to consultant handover at the beginning of each shift, usually at 8am. There was a printed handover sheet with limited information. The handover that we attended was unstructured and lacked overall leadership. For example, it didn't include any reference to allergies, incidents, medication errors and the handover was constantly being interrupted.
- Each critical care consultant took on lead responsibilities for a different area of service provision such as sepsis, tracheostomy, governance and informatics.
- The critical care unit was also staffed by trainee doctors from different backgrounds, usually anaesthesia and medicine. There were usually two trainees on duty per shift including out of hours.

Major incident awareness and training

- Major incident policies and protocols were in place and readily available.
- We did not see any evidence to demonstrate that the major incident plan had been practiced or tested.
- The latest peer review by the Cheshire and Merseyside Critical Care Network in March 2015 reported that there was no clear or robust contingency plan for business continuity if evacuation and relocation of the critical care service was required in an emergency.

Critical care

Are critical care services effective?

Good

Care was delivered in line with evidence- based, best practice guidance. The unit continued to collect and submit data for the intensive care national audit and research centre (ICNARC) for validation, so it was able to benchmark its performance against comparable units. This data showed that patient outcomes and mortality were generally within the expected ranges when compared with similar units nationally. The exception being for delayed and out of hours discharges where the unit's performance was slightly worse than the England average.

As part of their individual care plan all patients in critical care were assessed in respect of their pain management. Multi-disciplinary ward rounds took place each day that involved medical, nursing and pharmacy representation.

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 a critical care outreach service provided and a documented discharge pathway in place which included referral of all discharged critical care patients to the outreach team so that they could assess and monitor their progress and recovery.

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 the intensive care national audit and research centre (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 Cheshire and Merseyside Critical Care Network (CMCCNN). 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.
- Following the last CMCCN review in March 2015, the unit achieved most of the specification requirements. However, there were some areas of non-compliance. The review outlined that there was no clear business contingency plans for emergency evacuation of critical care; there were low numbers of registered nurses (the Intensive Care Society nurse to patient ratios were being met at the cost of bed availability); there was an under establishment of pharmacy, occupational therapy, respiratory physiotherapy and clinical psychology; there was no local unit based risk register; there was non-compliance with the North West skin bundle; there was a failure to put patient diaries in place for all level 3 patients and there was a failure to meet all aspects of NICE Guidance 83, 'Rehabilitation after critical illness'.
- There was a range of local policies, procedures and standard operating protocols in place, which referenced evidence based guidance and these were easily accessible via the trust wide intranet.
- We requested information on the critical care clinical audit programme. The evidence that we were given didn't describe what was included on the programme. However, we did see evidence of audit and results of the following; delirium audit – use of confusion assessment method in intensive care unit (CAM-ICU (2013)), deep vein thrombosis bundle audit (February 2015), ventilator acquired pneumonia bundle (2015) and the acute kidney injury bundle (2014).
- There was awareness amongst the staff of the delirium that patients can experience as a consequence of being cared for and treated in a critical care environment. The unit had conducted a delirium audit in 2013, which looked at compliance with CAM-ICU completion. The recommendations included raising awareness of delirium through education of nursing and medical staff and the introduction of a delirium checklist. We did not see evidence of any re-audit of CAMICU compliance.
- We asked for the results of audits relating to compliance with ventilator, skin and sepsis bundles but the time of writing, these had still not been received.
- The unit was also regularly collecting information on occupancy, times of admission and discharge, outreach activity, organ support, speciality of admission and patient age.

Pain relief

- There was access to the acute pain management team for support and guidance during the week and out of hours from the anaesthetic department.
- 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 an electronic pain scoring tool.
- In critical care the use of epidurals and patient controlled analgesia systems (PCA's) were overseen by the acute pain nurse specialist who was also a prescriber. The acute pain nurse specialist was also involved in delivering annual update training to critical care staff.

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 in the patient's notes.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.
- For those level 2 patients that were able to eat and drink, we saw that food was delivered to the unit and staff assisted patients as required.

Patient outcomes

- The unit participated in a range of national audits such as ICNARC, ICBIS (adult critical care transport audit) and the national cardiac arrest audit.
- The results from ICNARC showed that patient outcomes and mortality were generally within the expected ranges when compared with similar units nationally.
- There was an issue with the numbers of patients who experienced a delayed and/or out of hours discharge from the unit. For the period April to June 2015, the unit had 211 admissions and 140 (66%) of these experienced a delayed discharge from critical care once a decision had been made to discharge or step down. For the same period 30 patients experienced an out of hours discharge. Out of hours is defined as being after 10pm and before 7am.
- There was a critical care outreach service provided 8am to 8pm, Monday to Friday and during the morning shift at the weekends. There was a documented discharge pathway in place which included referral of all discharged critical care patients to the outreach team so that they could assess and monitor their progress and recovery.

Competent staff

- The critical care unit had two designated clinical nurse educators in post which equated to 1.5 whole time equivalent (WTE) posts. On occasions, as a consequence of sickness and/or absence, they were required to work clinically in the unit.
- Nursing and medical staff received an annual appraisal. By August 2015, divisional records showed that 75 nursing staff (72%) had received an appraisal in the last 12 months against a trust target of 85%. However, all medical staff, including consultants had received an appraisal in the past 12 months. Trainee medical staff stated that they were well supported and had an appraisal and revalidation process in place with good opportunities for training.
- The critical care manager was a band 7 and there were also 14 band 7 nurses working for the critical care service. Consequently, the band 7 nurse appraisals were undertaken by the band 8a Matron.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.
- We saw that 54% of the registered nurses working on the unit had a post registration qualification in critical care. Four more were due to start the post registration critical care module this year.
- Staff described a thorough induction programme for new starters to the unit, in addition to the corporate trust induction training. This included each new starter being assigned a mentor and undergoing a six week supernumerary period (supernumerary means they were not included in the daily staffing numbers so that they could learn without specifically being assigned patients to care for as an inducted member of staff would), which was extended if necessary. This included an introduction to the Step 1 critical care competencies, which staff were given up to 18 months to complete. Step 1 competencies have been designed to provide the core competencies required to look after an adult critical care patient. The clinical educators supported all

new staff at bands 5 and 3 for their first 12 months. This included their mandatory training and appraisals. After 12 months their on-going support was facilitated by a band 7 nurse.

Multidisciplinary working

- Multi-disciplinary ward rounds took place each day that involved medical, nursing and pharmacy representation.
- We received copies of one meeting entitled 'MDT Meeting' from July 2015. The meeting included input from nursing staff, consultant medical staff, physiotherapists, pharmacist and support staff.
- There was also evidence of multi-disciplinary working around the discharge of patients involving medical, nursing and allied health professional staff.
- There was a nurse led follow up clinic supported by a consultant intensivist, available for patients and relatives. This was held on the unit and provided both physical and psychological support for patients recovering from their critical illness.
- There was an outreach service Monday to Friday 8am to 8pm and during the mornings at weekends. The outreach nurses followed up all patients discharged or stepped down from critical care. Out of hours the outreach bleep was carried by the night nurse co-ordinators.
- Outreach data showed that the outreach team followed up 95.6% of 427 potential follow ups for the period 1 January 2015 to 31 August 2015.

Seven-day services

- A consultant intensivist was available seven days a week including out of hours.
- The physiotherapy team also provided a seven day service to the critical care unit during the day with an on call service out of hours.
- Dietetic services were available Monday to Friday and via on-call at weekends.
- Pharmacy services were available 7 days a week. A pharmacist visited the unit everyday including weekends and pharmacy services were available 24 hours a day, 364 days per year (excluding Christmas day).
- Imaging and diagnostic services were provided during the working week and then on-call out of hours and at the weekend.

Access to information

- The critical care unit used a paper based record system alongside a clinical information system. Physiological parameters were hand written onto a large care unit observation sheet located close to the bed space. There was also an electronic bedside system used for viewing blood results.
- On discharge from critical care a discharge summary was created for the nursing and medical teams taking over the patients' care. We saw that the medical handover sheet was completed by the critical care doctor and the nursing handover utilised a discharge pathway document. We noted that there was a specific checklist approach to the management of naso-gastric tubes and their associated use. This had been in response to a previous never event (serious, wholly preventable patient safety incidents that should not occur if the available preventative measures had been implemented by the healthcare provider) in June 2014 involving the management of naso-gastric tubes and transfer of a patient from critical care to the wards.

Consent and Mental Capacity Act including Deprivation of Liberty Safeguards

- Staff demonstrated an understanding of the issues around consent, capacity and deprivation of liberty safeguards (DoLS) for patients in critical care.
- Records showed that 96% of critical care nurses had received training in mental capacity as part of their mandatory training.
- There was an assessment of mental capacity recorded in the patient record. This was called the confusion assessment method for ICU or 'CAMICU' and was used in conjunction with the Richmond Agitation Scale, which measures the agitation or sedation level of a patient. Care plans stated that the CAMICU should be completed once every shift but this was not always evident in the four sets of patient records that we examined.
- Sedation breaks were implemented where appropriate. A sedation break is where the patient's sedative infusion is stopped to allow them to wake and this has been shown to reduce mortality and the risk of developing ventilator related complications. The sedative is then re-started if the patient becomes agitated, in pain or in respiratory distress.

Critical care

Are critical care services caring?

Good

Critical care services were being delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect. Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.

The unit was trialling the use of patient diaries, where appropriate, to help people come to terms with their critical illness experience. Follow up clinics were offered to patients who had been on the unit for more than 48 hours, two months after their discharge from critical care.

Compassionate care

- We saw that staff took the time to interact with people being cared for on the unit and those close to them in a respectful and considerate manner.
- We noted that staff were encouraging, sensitive and supportive in their attitude.
- People's privacy and dignity was maintained during episodes of physical or intimate care. Curtains were drawn around people with appropriate explanations given prior to care being delivered.
- Critical care did not undertake a specific relative's survey but staff told us that they gained their patient experience data from the friends and family test. However, looking at the friends and family data for March to August 2015 for four of the months there was no data recorded for critical care. For the months where there were friends and family returns the numbers of respondents were low and in single figures.

Understanding and involvement of patients and those close to them

- We saw that staff communicated with people so that, where possible, they understood their care and treatment. This was corroborated by a patient that we were able to speak with during the inspection.
- We spoke with the relatives of three patients on the unit. They were universal in their praise for the medical and nursing staff and reported that they had been kept informed of everything that was going on with their relative.
- The unit was trialling the use of patient diaries, where appropriate. Intensive care patient diaries are a simple but valuable tool in helping recovering patients come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown that patient diaries often help the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress.

Emotional support

- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relative's care and treatment plans.
- There was a senior nurse for organ donation in post who worked closely with the critical care team in managing the sensitive issues relating to approaching families to discuss the possibilities of organ donation.
- Follow up clinics were offered to patients two months after discharge from critical care when they had experienced a stay in excess of 48 hours.

Are critical care services responsive?

Requires improvement

We judged that in terms of responsiveness, the critical care service required some improvements to better ensure that people's needs were met.

When needed, patients were usually able to access critical care in a timely way although on occasions delays in admission meant patients were cared for in theatre recovery. The physical environment in theatre recovery was unsuitable for managing critical care patients as it was located opposite the designated paediatric recovery bay.

There was an issue with delayed and out of hours discharges. The four hour Intensive Care Society standard for discharging patients, when they are clinical ready for discharge to a more suitable environment was rarely met. The latest ICNARC data indicated that the length of delayed discharge was usually less than 24 hours. However, for the period April to June 2015, 70% of patients faced a delay in

their discharge of between 4 and 24 hours once a decision had been made that they were clinically ready for discharge. The unit was also performing worse than similar units for the numbers of patients who were discharged out of hours (10pm to 6.59am). Out of 211 admissions between April and June 2015, 30 had been discharged out of hours.

Patients and their relatives were able to access a nurse led follow up clinic for physical and psychological support following their critical illness.

Patients and their relatives were supported in accessing the systems in place for raising concerns and complaints

Service planning and delivery to meet the needs of local people

- There were bed management meetings held throughout the day to monitor and review the flow of patients through the hospital and this included the availability of critical care beds.
- There were no critical care beds on the Clatterbridge Hospital site. There was no escalation policy specifically for managing patients who deteriorated on the Clatterbridge Hospital site and required transfer to Arrowe Park Hospital for critical care.
- There were facilities for relatives to stay on the unit if they wished to and overnight, if needs be, in close by bedrooms.

Meeting people's individual needs

- Care plans demonstrated that peoples' individual needs were taken into consideration before delivering care.
- Interpreting services were available within the hospital if required.
- Once discharged from critical care, patients were followed up by the outreach team. The latest available intensive care national audit and research centre (ICNARC) data showed that the unit was performing comparably with similar trusts for early and late readmissions to critical care.
- There was awareness amongst the staff of the delirium that patients can experience as a consequence of being cared for and treated in a critical care environment. The unit had conducted a delirium audit in 2013, which looked at compliance with CAM-CU completion. The recommendations included raising awareness of delirium through education of nursing and medical staff and the introduction of a delirium checklist. We did not see evidence of any re-audit of CAMICU compliance.
- Patients discharged from critical care had access to a nurse led follow up clinic. This provided both physical and psychological support. The clinic was run by trained intensive care nurses one of whom was also a trained counsellor. Patients and relatives were also referred to the 'ICU steps' organisation, which provided support for people affected by critical illness.

Access and flow

- There was a trust policy, published in January 2015, which dealt with critical care referral, admission and discharge.
- The total critical care bed occupancy for the past three years was; 87% for financial year 2012/2013, 84% for 2013/2014 and 81% for 2014/2015. However, the bed occupancy figures did fluctuate throughout the year. For example, the daily occupancy for June 2015 varied from 61% to 106% and in July 2015, 61% to 94%.
- Patients were reviewed in person by a consultant within 12 hours of their admission
- We were told by senior staff that there were usually no delays in admitting a patient to intensive care. However, on three occasions during the past 12 months, three level 3 patients have been managed in theatre recovery overnight as there were no appropriate critical care beds available. The physical environment was unsuitable for managing critical care patients as it was located opposite a designated paediatric recovery bay.
- We did not find any occasions where elective surgery had been cancelled as a consequence of a critical care patient being nursed for an extended period in recovery although there were occasions where an elective case had been cancelled due to the unavailability of a critical care bed.
- There has been issues with delayed and out of hours discharges from critical care. The unit's latest ICNARC data confirmed that patients were rarely discharged within four hours of the decision being made that they were clinically ready for discharge or step down Intensive Care Society standard. Once a patient no longer needs critical care then it is not the right environment for them to continue to stay. There was an acceptance by the unit that the four hour target for discharge was not always met. The latest ICNARC data indicated that the length of delayed discharge was usually less than 24 hours. However, for the period April

to June 2015, 70% of patients faced a delay in their discharge of between 4 and 24 hours once a decision had been made that they were clinically ready for discharge.

- The design of the critical care areas meant that when a patient's discharge was delayed for more than four hours, the government's same-sex accommodation standard was often being breached. On such occasions, the breaches were not being reported via the incident reporting system.
- The unit was also performing worse than similar units for the numbers of patient who were discharged out of hours (10pm to 6.59am). Out of 211 admissions between April and June 2015, 30 had been discharged out of hours.
- The unit was performing better than similar units for the numbers of non-clinical transfers out. This meant that compared with similar critical care units in England, patients were not usually transferred because there was no bed available. If a transfer to another unit took place it was for a clinical reason such as the patent requiring specialist care, such as a neuro intensive care unit.

Learning from complaints and concerns

- For the period December 2014 to June 2015 the critical care service received seven complaints. Two were made about the high dependency unit (HDU) and the remaining five about the intensive care unit (ITU). The complaints comprised three about alleged poor communication between staff and patients, two related to staff attitude, one related to the loss of patient's property and one related to the lack of an available HDU bed.
- There was a lessons learned noticeboard displayed in the staff room, which included learning from complaints.
- Patients and their relatives were encouraged to speak to the critical care ward manager or consultant if they had any issues about the care and treatment they received during their stay. The critical care 'guide for relatives' also gave contact details for the local Patient Advice and Liaison Service (PALS) and the trust's specific complaints email address.

Are critical care services well-led?

Requires improvement

There was no clear, shared vision or strategy for the unit. However, the trust had developed a five year strategic document to address some of the issues within critical care.

There was a governance structure in place though at times it was unclear how risks were being managed and reviewed. As there was no local risk register, it was unclear what controls were in place to mitigate risks locally.

The trust had sought to address some of the negative outcomes of the NHS staff survey and medical staff in critical care felt that there had been an improvement in engagement with the executive team in the 12-18 months prior to the inspection.

The nursing structure on the unit meant that senior band 7 nurses were being managed on a day to day basis by a band 7 intra-unit nurse manager.

Several staff reported the trust as being 'insular' and told us this tended to stifle innovation and staff development opportunities.

Vision and strategy for this service

- We saw a five year strategic framework document for the medical and acute specialities division, which included a four and a half page section on critical care. However, none of the critical care staff that we spoke with were able to articulate any local vision or strategy for the critical care service other than 'to provide the best critical care for our patients'.
- The five year divisional strategy document reported a risk that monitors and ventilators were more than seven years old, which meant that the manufacturer service contracts were null and void. The mitigation recorded was that a business case for capital funding would be developed for new monitors and ventilators and presented to the board. The intensive care society standards state that there must be a program in place for the routine replacement of capital equipment so it was unclear why a business case had to be developed.
- The existing critical care unit footprint and bed layout were outdated and did not meet the latest guidance published by the Department of Health in 2013. Health building notes (HBN), published by the Department of

Health, give best practice guidance on the design and planning of new healthcare buildings and the adaptation/extension of existing facilities. The latest guidance (HBN 04-02) was published in 2013 and provides the most up to date best practice guidance for critical care units. The unit at Arrowe Park hospital did not meet this guidance and this had been identified in the divisional five year strategy 2014-2019. The strategy referred to a business case being developed for a redesigned unit but there was no timescales included as to when this might happen.

Governance, risk management and quality measurement

- There was no locally held critical care risk register. Some critical care risks related to the environment were reported on the trust wide register. However, we identified that the emergency transfer equipment did not meet the latest Intensive Care Society standard as it could not be secured in the ambulance. Staff did not seem to know that it did not meet the correct standards and it was not recorded as a risk on the risk register.
- The critical care unit was a member of the Cheshire and Merseyside Critical Care Network (CMCCN). Membership of the network enabled the unit through collaborative working with commissioners, providers and users of critical care to focus on making improvements where they were required. However, despite a review undertaken by the CMCCN in March 2015, some of the highlighted issues had not been addressed at the time of the inspection such as a the lack of a local risk register.
- Senior medical and nursing staff were agreed on the main risks to the service, which were environment and estate, out of date equipment and the recruitment and retention of nursing staff but these were not recorded as a risk locally and it was not clear what controls were in place or what steps had been taken to mitigate these risks.
- There was a governance structure in place though it was not always clear how critical care risks were being reviewed and escalated. Critical care was not represented at two of the four divisional governance meetings based on the minutes that we reviewed. These were the February and June 2015 meetings.
- We requested minutes from the last three meetings of the trust wide critical care delivery group although only received one set of minutes from November 2014. At this meeting both divisional senior clinicians and managers met with the wider trust medical director and deputy director of nursing to discuss critical care activity, outcomes, risks and performance. Again the risks relating to the environment and out dated equipment were discussed. The action arising at the time was for a refresh of previous capital bids, which were to be added to the capital programme. Though it was not clear whether these bids had yet been successful.
- A divisional monthly good practice meeting was held to which all staff were invited although it wasn't clear how many critical care staff were able to attend.

Leadership of service

- There was a band 7 intra-unit nurse manager in post who managed the unit on a day to day basis. There were also 14 band 7 nurses working within the critical care service. This structure meant that the manager was unable to effectively appraise the senior nurses with this process being undertaken by the band 8 matron instead.
- The critical care unit had a designated consultant clinical lead and the nursing team was led by a team of experienced senior nurses.
- The critical care service had recently instigated a more robust approach to managing sickness and absence. This included ringing the Matron as well as the nurse in charge of the unit to explain the reasons for staff sickness. The sickness and absence figures recorded over the last six months showed a 0% absence for medical staff and a reduction in nurse sickness and absence from 8.2% in April 2015 to 6.7% in August 2015.
- We did see some evidence of silo working. The critical care unit was located next door to theatre recovery and the two departments had a common issue in that critical care patients were at times managed in theatre recovery when there were no critical care beds available. The two areas sat in different organisational divisions and it was not clear if any joint work had been undertaken to resolve this issue.

Culture within the service

- Staff were open, honest and happy to tell us what it was like to work in critical care.
- There were a number of staff who had worked in the critical care service for many years. In addition many of the staff were recruited locally. This had its benefits in terms of a relatively stable workforce that enabled

continuity. However, several staff reported the trust as being 'insular' and told us this tended to stifle innovation and staff development opportunities. For example, some staff didn't see the value in attending external critical care conferences for personal and professional development or looking at alternative ways of working. There was a view expressed by some of the staff we spoke with that there was little interest in 'looking over the horizon' to see what other critical care units were doing.

Public engagement

- The trust website gave a brief overview of the critical care services delivered at Arrowe Park Hospital.
- In addition, the critical care unit had produced a guide for relatives, which gave simple, practical information to people whose relative was admitted to critical care. It included information on what to expect of a critical care unit, visiting times and who the various staff were in the unit.

Staff engagement

- Medical staff reported that there had been improvements over the 12-18 months prior to the inspection in terms of engagement with the executive team and that 'they' felt they were now being listened to much more.
- In the 2014 staff survey, the trust had 18 negative responses out of 30. These included, only 22% of staff reporting good communication between senior management and staff (national average 30%) and for staff who would recommend the trust as a place to work, the average score was 3.29, on a scale of 1-5, with the national figure being 3.71. The trust had developed an action plan to improve this position and there were positive signs of improvement at the time of the inspection.

Innovation, improvement and sustainability

- Several staff reported the trust as being 'insular' and told us this tended to stifle innovation and staff development opportunities. For example, some staff didn't see the value in attending external critical care conferences for personal and professional development or looking at alternative ways of working. There was a view expressed by some of the staff we spoke with that there was little interest in 'looking over the horizon' to see what other critical care units were doing.

Maternity and gynaecology

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

Information about the service

Wirral University Teaching Hospital NHS Foundation Trust provides maternity and gynaecology services from Wirral Women and Children's Hospital which is located on the Arrowe Park site adjacent to the main Arrowe Park Hospital.

The gynaecology service provides outpatient care for approximately 8,000 patients and performs 4,500 surgical procedures per year. The ward comprises of 14 inpatient beds and 12 day-case beds, providing 24 hour care for patients admitted for both elective (planned) and emergency treatment. As part of the pregnancy counselling clinic, the ward also provides care for patients undergoing medical termination of pregnancy and patients admitted with complications relating to their pregnancy. There are also two dedicated gynaecology theatres.

Maternity services at Arrowe Park Hospital supported 3,266 births between 2013 and 2014.

The delivery suite has ten delivery rooms, the majority of which are en-suite and have birthing pools. It is situated next to the midwifery led unit (MLU) and triage area.

The midwife led unit has five home-from-home rooms and two pools for water-births. This area is totally staffed by midwives. There are two designated maternity theatres directly linked to the delivery suite and MLU.

The joint antenatal and postnatal ward has 26 individual rooms each with en-suite bathrooms. There are four 'transitional care' rooms used when babies need additional support that can be provided outside the Neonatal Unit.

The trust provides antenatal and postnatal clinics throughout the Wirral area and parts of Liverpool. These are based on three locality teams, Birkenhead, West Wirral and Wallasey.

We spent time on the delivery suite, antenatal/post-natal ward and the gynaecology ward. We also attended antenatal and gynaecology clinics and visited the theatres recovery room on the delivery suite.

We talked with 12 women and six family members receiving a service from the maternity and gynaecology service. We recorded contact with 40 members of staff from the areas we visited including the clinical director and head of midwifery for the service; the quality assurance co-ordinator, consultants, junior doctors, ward sisters, shift leaders, matrons, trained nurses and a range of midwives, health care assistants and ward clerks. This number also included student, recently qualified and newly recruited midwives.

We reviewed the entire pregnancy care pathway for four women and the 'admission notes' only for one woman.

Maternity and gynaecology

Summary of findings

Staffing arrangements did not always ensure that enough numbers of skilled and knowledgeable midwives were on duty to consistently meet individual needs. Rostering processes lacked robustness, they allowed for staff to be rostered in more than one area at a time and there was a lack of senior control of changes to the roster.

There was evidence of inconsistency in the reporting and review of serious incidents. Incident investigations including root cause analysis lacked robustness in their approach and remedial action planning. Improvements were needed in the provision of feedback so that staff were able to improve practice through learning from incidents.

There was no monitoring procedure in place to identify the location of equipment required by community midwives. In addition, there was no evidence the equipment was regularly checked and we found suture material used to mend peritoneal tears where use by dates had expired in 2010.

Some equipment, including oxygen cylinders, was provided to mothers in preparation for a home birth but it was unclear whether risk assessments were completed and whether guidance as how to safely store the equipment was provided to families

The record keeping systems did not guarantee that accurate and up-to-date information about patients would be readily available.

Access to the midwifery led unit could be limited because midwives were often diverted from the unit to work on the delivery suite if this was short staffed and the times when it was unavailable had not been monitored.

Interpreters were available for patients whose first language was not English. However, patient information leaflets were not available in any other language than English.

Best practice guidance in relation to care and treatment was followed and plans were in place to participate in national and local audits. However, the plans were not always effective because many audits had been discussed but not commenced.

Outcomes for women were similar to national averages. Women were assessed for their pain requirements and provided with the appropriate level of pain relief.

The trust was awarded the UNICEF baby friendly accreditation in July 2014 for their work in relation to supporting breastfeeding mothers and parent and infant relationships.

The service encouraged and supported learning and development. Emergency response training was robust and effective.

Patients were cared for with kindness and compassion. Patients were positive about the standard of care and treatment provided by the maternity and gynaecology services.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

There were some improvements required to provide women with a safe maternity service at all times.

The staffing levels for the midwifery services were under review to ensure they were based on an approved tool Birth Rate Plus staffing tool. Rostering processes lacked robustness, they allowed for staff to be rostered in more than one area at a time and there was a lack of senior control of changes to the roster. There were some shifts identified as being staffed below the expected numbers and contingency plans were ineffective.

The service did not make sure staff followed best practice medication protocols and midwives were not always provided with enough information to understand and so comply with new protocols.

We were not clear on systems or processes in place to ensure that mobile emergency equipment for home births was readily available for community midwives. There was no monitoring procedure in place which identified where the equipment was at any given time. In addition, there was no evidence the equipment was regularly checked and we found suture material used to mend peritoneal tears expired in 2010.

Some equipment, including oxygen cylinders, was provided to mothers in preparation for a home birth. Midwives were uncertain about whether risk assessments were completed and whether guidance, such as how to safely store the equipment was provided to families

Records did not always provide up to date information and were not accessible to all medical staff. Safeguarding protocols were in place however a system of flagging staff to women who were at risk was not in use. The management of safeguarding alerts was not robust because paper records could be mislaid and were not always stored securely.

Medical staffing met the recommended guidelines in relation to allocated consultant time on the delivery suite.

The training and practice in relation to dealing with medical emergencies in maternity and gynaecology was effective, well-rehearsed and promoted the safety of women in labour and babies born on the unit.

Incidents

- There were paper and electronic incident reporting systems. Nurses, midwives and doctors told us the systems were easy to use. Guidance was available to support staff using the system including bank and agency staff.
- Between January 2015 and September 2015 one never event had occurred in maternity. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The event had been investigated using a root cause analysis (RCA) process and action taken to prevent a repeat of this incident. Midwives and maternity shift leaders were able to articulate the changes made as a result of the analysis which included consistently using a larger piece of equipment. However, they did not feel they were given the opportunity to offer alternative solutions or discuss the rationale for the decision. We asked senior managers about monitoring the changes and this had not been completed.
- The second root cause analysis investigation we reviewed concerned a medication error. This investigation lacked detail as all the possible reasons for the error. The actions to be taken did not include telling all staff about the risk and the lessons learnt.
- The trust provided a list of approximately 341 incidents raised by staff between 1 March 2015 and 9 September 2015. Information was not available during our inspection on trends related to individual incidents reported for this time. We were not able to identify clear processes in incident trend identification and management.
- The level of harm allocated to incidents did not always match the National Reporting and Learning System (NRLS) criteria. For example we found one of the RCA's reviewed had been rated as 'very low harm' which is not an NRLS category. On reviewing this information we found the incident was more in line with the NRLS definition of 'moderate harm' because the event had resulted in more invasive treatment than originally planned.

- A risk and governance manager responsible for investigating and auditing incidents, initiating reviews and risks assessments had been employed for maternity services. This person described the investigation processes, the forums for managing risk and sharing information and learning from incidents. Methods described included a service newsletter called 'Little gems' in maternity; updates published on the trust internal intranet site; weekly care improvement forum (CIF) meetings and the use of white boards on the gynaecology unit, delivery suite and antenatal/ postnatal units to highlight lessons learnt under the heading 'theme of the week' which was then discussed at each staff handover.
- We reviewed a copy of the newsletter 'Little Gems'. Safety instructions were provided but did not include specific information about lessons learnt from incidents or the changes implemented as a result.
- The delivery suite whiteboard at the time of the inspection showed a key theme related to the administration of Syntocinon and stated that this drug must be prescribed. Midwives were not clear about why this was the case. The trust's medication policy did not provide specific information about this medication and no concerns about this medication had been raised in the governance documents or on the risk register we reviewed. National Institute for Health and Care Excellence (NICE) guidelines (CG190) dated December 2014 stated that use of Syntocinon before or during birth requires discussion with an obstetrician. We reviewed the notes and delivery record of three women who required support and used medication to start labour. Each woman had received Syntocinon intravenous infusion to start their labour without a written prescription or evidence of a discussion with an obstetrician.
- Monthly perinatal and morbidity meetings for maternity and gynaecology were held and open to all staff. Meeting minutes showed that doctors, nurses and midwives of all seniority attended. The records demonstrated that a full discussion and analysis of the issues relating to deaths or injury took place and conclusions were drawn in relation to the immediate action taken to improve individual practice if appropriate, however it was not clear when information from this meeting was shared with ward level staff who did not attend meetings.
- In gynaecology, we saw that learning from incidents was cascaded through a twice weekly clinical incident meeting, quarterly safety meetings, ward meetings, newsletters, staff safety huddles (very small quick meetings) led by the ward sister and payslip messages.
- The trust's women and children's division, which included maternity and gynaecology, scored well for reporting errors, near misses or incidents in the 2014 national NHS Staff Survey; 127 gynaecology and midwifery staff participated in the survey and 95% had reported errors, near misses or incidents they had witnessed in the month before the survey.
- There were robust systems in place to monitor and review postpartum haemorrhages.
- Staff said that although they felt comfortable reporting incidents, the system could be improved if the report could also be made anonymously. This was reflected in the staff survey because although 95% of staff said they had made reports only 60% agreed they felt secure raising concerns about unsafe clinical practice.
- Letters, policies and discussion with staff showed that gynaecology and maternity services followed a clear protocol in relation to duty of candour and informing patients about events which had affected them.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. There are different topics to review depending on the specialism.
- All ward areas we visited displayed the results of their safety thermometer for patients and public to see.
- The delivery suite's July 2015 results showed that there had been no falls or pressure ulcers during that month. Staffing was not included in this information.
- The gynaecology wards safety thermometer was on display and showed that staffing was correct 97% of the time. There had been no falls or pressure sores reported.

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile in the 12 months prior to the inspection.
- The areas we inspected were visibly clean and tidy.

- Hand hygiene audits were completed monthly. They looked at hand washing and cleansing, correct clothing and the use of aprons and gloves. The results displayed on the delivery suite showed 100% compliance.
- There was an appropriate supply of hand gel, soap and personal protective equipment such as aprons and gloves.
- There was signage giving instructions to friends and family about personal hygiene, infections and the health of visiting siblings.
- Records indicated that antenatal and admission blood tests to screen for infection were completed.
- The gynaecology ward was clean and hand hygiene audit scored green (good) and the wards infection control assessment scored 100% compliance in May 2015.

Environment and equipment

- The layout and design between departments across the maternity service ensured that staff could provide support to patients who needed prompt medical intervention and mitigate any delays in transfer between the delivery suite, obstetric theatres and the neonatal unit.
- Access controlled doors and close circuit monitors were in place to monitor visitor access to the delivery suite and antenatal/postnatal units.
- Each clinical area had resuscitation equipment readily available. There were systems in place to ensure it was checked and ready for use on a daily basis. Records indicated that daily checks of the equipment had taken place on the wards we visited.
- The delivery suite audited the equipment check records and set a target 75% completion each month which had been achieved most of the time. If missed, a reminder was written in the equipment check file and information about the importance of completing these checks was also highlighted in the 'Little Gems' newsletter.
- We were not clear on systems or processes in place to ensure that mobile emergency equipment for home births was readily available for community midwives. There was no monitoring procedure in place which identified where the equipment was at any given time. Emergency equipment held by the community midwives was not checked and we found that the suture material used to mend peritoneal tears and episiotomy cuts was not fit for purpose because the use by date expired in 2010.
- Some equipment, including oxygen cylinders, was provided to mothers in preparation for a home birth. Midwives we spoke to were uncertain about whether risk assessments were completed and whether guidance, such as how to safely store the equipment was provided to the families.
- Service level agreements were in place to ensure equipment was maintained and serviced. Equipment we reviewed was fit for purpose and had appropriate maintenance checks in place.
- Cardiotocography (CTG) equipment used by midwives to monitor the baby's heart rate and contractions of the uterus during labour were in place. Records indicated it was appropriately monitored and calibrated to ensure accurate readings.

Medicines

- We reviewed the medication records of six patients. These records were completed appropriately including information about allergies.
- Medicines, including intravenous fluids, were stored appropriately.
- We saw that procedures were in place which ensured medicines requiring refrigeration were stored within the correct temperature, and appropriate checks were made.
- Controlled medication was stored securely and had appropriate checks in place. The controlled drug entry log on the antenatal units, gynaecology unit and obstetric theatres indicated that this medication was checked by two qualified staff at the change-over of each shift and before administration.

Records

- Some care records were incomplete and did not provide ready confirmation that best practice guidance had been followed. For example, risk factors for venous thromboembolism (VTE) during antenatal care had been reported but not repeated during or after delivery. Two of the four women had their observations including scores fully recorded during birth in keeping with the NICE guidance. Three women had required monitoring post-delivery and this had been document for only two.
- Some clinical information needed to assess risks was not mandatory on the electronic booking system and so important information may not be requested for example the outcome of previous pregnancies.

- When the unit was busy the electronic system was difficult to use and we identified an 18 hour delay in birth records being updated by staff and the incident records indicated this had occurred previously. There wasn't a system in place to ensure all written records completed by midwives remained on the wards until it was entered onto the electronic system. An analysis of how to solve this problem had not been undertaken.
- The electronic record keeping system was monitored and exception reports sent to identify which records were incomplete. We saw, however, that this information was not always accurate.
- Discharge reports and referrals were made to health professionals through the electronic recording system. Women were also given a copy of the information sent to their GP which included the date of birth, sex and weight of the baby and whether mother was breast or bottle feeding. The incident reports indicated that at times there could be problems with the electronic system because the electronic information did not always activate and send out letters as required.
- We read through the pregnancy communication books carried by three women and entries indicated that midwives and other health professionals used these to record visits and tests as appropriate.
- We reviewed the complete care pathways for antenatal, delivery record and postnatal information for four women. All the women had individualised care plans for pregnancy and labour, each had received appropriate antenatal screening and assessment of risk. Named midwives or consultants had also been allocated.

Safeguarding

- The women and children's services worked in keeping with safeguarding and child protection policies including female genital mutilation (FGM) policy to identify vulnerable babies and a child abduction policy. Midwives were able to describe the baby abduction protocols they would follow.
- There were three systems for communicating safeguarding concerns between the safeguarding team, midwives and medics which may allow for human error.
- At the time of the inspection there was no safeguarding or child protection alert codes used to identify vulnerable patients or those subject to child protection protocols. Staff were required to access each individual record to identify any safeguarding concerns.
- Shift leaders printed safeguarding information received from emails which was uploaded into the electronic records system accessed by permanent staff. Paper forms were filed in a single folder, in order of expected delivery date and kept in the midwives office. This was accessible to staff who could not log onto the system.
- In the delivery suite office we noted two safeguarding forms loose on a desk with a lot of other papers, staff mentioned these needed to be uploaded and filed, this showed however there could be delays in the information been uploaded and filed or they could be misplaced.
- The trust was introducing a separate electronic system for managing safeguarding which would be uploaded by the safeguarding team. We observed this system in use and saw that midwives had to sign out of one system into another. The complexity of these systems could lead to safeguarding issues being missed by staff because accurate, complete and up to date information could not be guaranteed.
- The trust's integrated safeguarding team was well established and had links to the women and children's division but it was acknowledged that the team needed to expand. The named midwife retired and a replacement came into post in August 2015.
- There were two safeguarding lead midwives in the integrated team with responsibility for identifying and dealing with female genital mutilation; domestic abuse and child protection.
- We saw evidence in patient records of discharge planning documents which had been completed before birth for women with a safeguarding concern but no ward based discharge meeting had taken place during the postnatal period. This meant the plan was not reviewed and updated with the patient and social worker before the baby left the hospital.
- The mandatory training data provided by the trust confirmed 89% of maternity and gynaecology midwives and nurses had completed level three children's safeguarding training.
- We were informed that key consultants with safeguarding responsibilities had completed level four safeguarding training however evidence was only provided to confirm staff had received level two and three training.

Mandatory training

Maternity and gynaecology

- Maternity and gynaecology training data from the trust indicated that between March and August, 27 out of 32 medical and dental staff and 327 out of 342 midwives and nurses working for the women and children's directorate had completed mandatory training.
- The trust had a rolling program of training in place to make sure all staff were up to date. Midwifery and gynaecology staff worked through a specialist programme designed to include mandatory as well as ongoing competency training.

Assessing and responding to patient risk

- Midwives either used a handheld doppler instrument or a cardiotocography (CTG) monitor to listen to a baby's heart rate during labour. This allowed them to identify if a baby was becoming distressed and take urgent or emergency action if required.
- We witnessed the management of three patients whose condition was deteriorating and saw robust management systems which were expertly implemented.
- The World Health Organization (WHO) five steps to safer surgery checklist was in use in maternity. This is a set list of safety questions that anaesthetists, surgeons and theatre midwives have to be asked and have answered verbally before, during and after a caesarean section to make sure women and babies are kept safe during the procedure.
- Midwives said that the trust had recently changed obstetric emergency cover for theatres which now used staff from main theatres. The trust monitored the effect of this change and found it took 4 minutes for a scrub nurse to arrive from the main theatres to the obstetric theatre for a category 1 (emergency) caesarean section. The National Institute for Health and Care Excellence (NICE) guidance for caesarean sections (CG132) states these must be carried out as quickly as possible and within 30 minutes of making the decision. Reports indicated the trust continues to monitor the effect of this change on the time taken to perform an emergency caesarean section at night to make sure the change did not have a negative effect on safety.
- The community midwives delivery bag and emergency box did not meet best practice guidance because they did not include all of the medication listed in the Kings Fund safer births initiative 2008.

Midwifery staffing

- The trust employed six advanced midwifery practitioners who were able to complete complex procedures, prescribe medication and work alongside middle-grade doctors.
- The ratio of midwives to babies born was 1:25, which was better, on paper, than best practice guidance which suggested a ratio of 1:28. However, we found that the way rosters were organised did not always meet the needs of patients. The head of midwifery stated the current staffing for the midwifery service was satisfactory and staffing was being continually reviewed using a robust protocol. This review looked at staff numbers and the complexity of the patients accepted by the service using the Birth Rate Plus best practice guidance for staffing ratios in midwifery services. Nine additional midwives had been employed by the time of the inspection.
- Management of the electronic rostering system meant the skill mix on the delivery suite and antenatal/ postnatal unit was unpredictable. Staff told us that the same staff could be rostered onto different units at the same time.
- Midwives were also able to swap shifts without reference to shift leaders or the maternity matron and so skill mix and experience could not be guaranteed. Shift leaders said they could not trust the information and so did not know who to expect for each shift which made it difficult to judge whether the unit was actually short staffed until the beginning of the shift.
- We reviewed a copy of the roster sheet printed for the week commencing 14 September 2015 and there were hand written adjustments on each shift and day up to and including the 17 September 2015. It wasn't possible from this working document to confirm whether the staffing establishment on the delivery suite and antenatal/postnatal unit had been met for these days.
- The number of staff required on the midwifery unit was unclear as the staffing policy indicated there should have been eight midwives on duty to include a shift co-ordinator who would have been supernumerary but the staffing establishment board showed that seven midwives and a midwifery care assistant were required.
- The staffing establishment board on the midwifery unit for the days of the inspection showed that the staffing establishment had been met. However, we found that the unit was not resourced as stated on the board. On the evening of the 16 September 2015 we found that four midwives (three band 6 and one band 7) reported

for the night shift on the delivery suite. The situation had been escalated to the maternity matron and two community midwives were asked to come on duty and work until midnight. These midwives had already worked during the day. In addition, a midwife from the ante/postnatal ward (ward 53) was asked to move to the delivery suite until the additional staff arrived and a midwifery health care assistant, who had begun work at 7.30am, stayed on the ante/postnatal ward until midnight.

- The level of care required by women on the delivery suite on the evening of 16 September 2015 was high. The number of women requiring one to one care at that time meant that the coordinator could not maintain their supervisory role at all times and this increased the risk of a slower response to any potential emergency.
- At the time of the inspection, we also witnessed midwives and health care assistants called away from nursing duties to answer the door. The staffing establishment provided by the trust showed there should be a ward clerk on duty 24 hours a day. However, long term sickness meant there was only ward clerk cover until the early evening for ward 53 and the delivery suite but there was 24 hour cover in the maternity triage unit.
- A safety status check was in place to review and respond to the needs of patients, staffing and other issues on the units and this took place every four hours during the day. Areas could be scored red, amber or green and if a 'red' or 'amber' was scored, the lead nurse or midwife was expected to follow a protocol to improve or monitor the situation. However, when we reviewed the status check on the delivery suite, there was no evidence that staff had used descriptors to decide the level of risk in each area. For example, on 16 September 2015 the delivery suite had scored 'green' at 4pm, when a patient had needed emergency assistance and the unit had not been fully staffed because a midwife became unwell.
- We discussed the staffing of the delivery suite with an on-call community midwife who was also a supervisor of midwives. This midwife was confident the unit was safe and would remain so because additional staff were on call.
- Staffing issues continued into the morning of 17 September 2015 and impacted on the community because the community midwives who had worked until midnight the previous night requested a change of shift.
- Staffing issues were also evident on the 18 September 2015 at the community midwives booking clinic at Arrowe Park Hospital because community staff had been called in to improve staffing levels in the hospital the night before. This meant that one community midwife had to cover two booking clinics.
- In the gynaecology service there were no staff vacancies. The ward rosters were well organised and completed by the ward sister.

Medical staffing

- The service had 60 hours consultant cover in place for the delivery suite, which meant that the service met the best practice recommended guidelines for safer childbirth.
- Ten consultants rotated so that one consultant provided 42.5 hours of this cover each week between 8:30am and 5pm, Monday to Friday.
- There was a robust process for the recruitment and induction of locum doctors.
- Clinical handovers of patient information were detailed.
- Information we received indicated systems for providing replacement medical cover were not always effective. On one occasion a consultant documented that they were on duty for 24 hours and there was no formal arrangement in place to get cover for a shift. The process was for consultants to phone each other individually. The shift organiser did not know which consultants were available to call on or handover to onsite.

Major incident awareness and training

- Well-rehearsed major incident plans were in place and scenario training for staff was provided and updated yearly.
- There was a clear business continuity plan and action flow chart for the management of patients in adverse situations such as infection epidemics. The plan included liaising with other nearby maternity units to make sure women could be redirected as required.

Maternity and gynaecology

Are maternity and gynaecology services effective?

Good

Women's care and treatment was planned and delivered in line with current evidence-based guidance, standards and legislation.

The trust was awarded the UNICEF baby friendly accreditation in July 2014 for their work in relation to supporting breastfeeding mothers and parent and infant relationships.

Outcomes for women were similar to national averages. Women were assessed for their pain requirements and provided with the appropriate level of pain relief.

There were opportunities for professional development for midwives and nurses in women's services. Multidisciplinary team working was well planned and effective.

Newly employed and qualified midwifery staff had received appropriate training for them to carry out their role effectively.

There were arrangements in place to audit the care and treatment provided however a number of planned audits had not been completed.

Evidence-based care and treatment

- Care pathways were designed in line with best practice guidance from the relevant Royal College or advisory agent. For example, pathway 64, the congenital anomaly pathway, followed the National Institute for Health and Care Excellence (NICE) antenatal care guidance 62. All policies and procedures reviewed identified the best practice guidance pathway on which it was based.
- Copies of policies and guidelines were available to all staff via the trust intranet.
- There were specific care pathways for certain conditions, such as sepsis, in order to standardise and improve the care for patients.
- The trust was compliant with NICE guideline 74 for caesarean sections and this was being monitored.
- The women and children's division had a forward audit action plan which identified audits that had been completed and planned for the maternity and gynaecology services. It was noted that 25% of audits for the maternity services were overdue.
- In June 2015 the NHS Screening Programme provided a quality assurance report in relation to the maternity service with observations and recommendations. This review identified areas of good practice such as the work carried out by the specialist midwife for infectious diseases. This review also made recommendations and identified areas for improvement and we saw that an action plan had been developed and discussed at a clinical governance meeting in September 2015.

Pain relief

- Care plans showed that all women had received pain assessments and that appropriate pain relief was provided.
- We spoke to ten women about pain control who all confirmed they had received the appropriate pain relief as necessary.
- Pain management was timely and effective. Epidural, Entonox, pethidine and codeine analgesia was readily available.
- At the time of the inspection we saw there were often two anaesthetists on the delivery suite and advanced nurse practitioners whose role included prescribing effective pain relief in keeping with prescribing protocols.
- For women with complex needs or safeguarding concerns, liaison and discussion about pain control with the person and their social worker, support worker or birthing partner always occurred. Midwives described scenarios and action taken when they had attended to vulnerable women during labour.

Nutrition and hydration

- The trust was awarded the UNICEF baby friendly accreditation in July 2014 for their work in relation to supporting breastfeeding mothers and parent and infant relationships.
- The trust had completed an audit during February 2015 to check whether breastfeeding had been discussed with women at an early stage. The report provided insight into steps that could be taken to improve breast feeding rates.

- Mothers with babies on the neonatal unit were supported to express milk for them. A breastfeeding coordinator and volunteers provided support to mothers and gave advice.
- Women on the maternity and gynaecology units were provided with snacks, meals and drinks while on the unit, fluid balance charts were completed so that oral intake could be monitored when required and when intravenous fluids were administered.

Patient outcomes

- Patient outcomes were monitored by the service through a maternity performance dashboard which used quality indicators recommended by the Royal College of Obstetricians and Gynaecologists.
- Between July 2014 and June 2015 the incidences of perinatal mortality at the trust were in line with expectations and the crude rate was also similar to the national picture.
- The rates of normal vaginal delivery for the period January 2015 to May 2015 ranged from between 60.6% and 67.5% which was similar to or better than the national average (61%) but worse than the trust's internal target of 70%.
- The number of women who had an instrumental delivery for the period January 2015 to May 2015 ranged from between 7.5% and 13%. The trust monitoring process showed that failed instrumental delivery did not exceed 1.1% for the same period.
- Elective and emergency caesarean delivery was comparable with national targets (26%) for combined rates of elective and emergency caesarean sections reporting 24-27% for the period January 2015 to May 2015.
- The percentage of women transferred from the midwifery led unit (Eden) to the consultant led delivery suite between January 2015 to May 2015 was between 17.7% and 32.4%, which was better than the trust's target of 40%.
- The percentage of women with 3rd or 4th degree peritoneal tears for the period January 2015 to May 2015 was between 1.4% and 2.2%, which was better than the trust's target for this to happen no more than 4% of the time.
- Meconium (early faeces) aspiration is when a baby about to be born breathes a mixture of meconium and amniotic fluid into the lungs. This can be a serious event which can occur for a number of reasons including a long birth and aging placenta. The trust recorded the numbers of meconium aspirations (MA) monthly, which showed that between January 2015 to May 2015, performance in this area was mixed and ranged from a low of zero occurrences in a month to a high of three. The trust's target was for this to occur on no more than two occasions a month.
- The trust performed better than their target for deliveries which had involved shoulder dystocia which is when a baby's shoulders become stuck and do not pass easily through the vagina.
- The trust was not always compliant with NICE guidelines for the induction of labour. For example we saw that a planned induction had been postponed resulting in the pregnancy lasting longer than NICE guidance [CG70] which recommends that women are induced by 42+0 weeks to avoid the risks of prolonged pregnancy.
- There were five unplanned admissions from maternity to the intermediate treatment unit between January and August 2015. Records confirmed all events had been discussed and reviewed by clinicians and midwives.
- The maternity service supported women to adopt healthier lifestyles whilst pregnant. The average percentage of women smoking went down (improved) between booking and delivery date.

Competent staff

- The antenatal and newborn screening quality assurance visit report for 2015 showed there was a detailed in-house training programme and new starter induction programme for clinicians who completed an examination of newborn babies.
- Figures supplied by the trust confirmed approximately 94% of doctors had up to date appraisals.
- Midwives received appropriate supervision because there were approximately one supervisor of midwives to every 16 midwives which was slightly less than the expected number. However only 77% of midwifery, maternity and gynaecology staff had completed their annual appraisal.
- Clinical and midwifery staff completed the practical obstetrics multi-professional training which included working through real time scenarios and reflection on their practice. Trust data confirmed this training was

provided on a monthly rolling program. Midwives received training and frequent opportunities to practice interpreting the results of cardiotocographys (CTGs) in order to develop their expertise.

- We interviewed 15 midwives ranging from bands 5 to band 7 and each confirmed the trust provided opportunities for training and supported professional development. Midwives were encouraged to train as mentors, supervisor of midwives and complete specialist courses.

Multidisciplinary working

- The trust enabled effective and seamless multidisciplinary joint working between the units, allied health professionals, the community midwives, including an independent maternity service provider.
- There were service level agreements and protocols for access to specialist midwives. We witnessed positive interactions and liaison with general practitioners and pharmacy which resulted in positive outcomes for patients with complex social and health needs.
- Paediatricians were on call for the maternity unit and midwives were aware of which paediatrician was on-call outside of normal working hours. There was always medical cover for newborn babies.
- There was good liaison between midwives and nurses on the neonatal unit. We witnessed prompt access to medical and surgical intervention and this was available 24 hours a day, seven days a week.

Seven-day services

- Consultants were on site during normal working hours and were available on call at evenings and weekends. If a consultant lived more than 20 minutes away they slept at the hospital to provide the on-call cover.
- Imaging and radiotherapy was available out of hours.
- Pharmacy was available seven days a week.

Access to information

- Community midwives used handheld electronic records and were able to access the same information as midwives on the wards.
- Locum doctors did not have access to the electronic system and so their notes were written up in the paper records. Midwives made a note on the electronic system to refer each other to the pink file to find notes made by locum doctors. This caused some delays in accessing information and the issue was recorded on the maternity risk register.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke to 12 women who said they had been provided with enough information to make an informed decision about their care and treatment.
- Staff described the different types of consent and we witnessed staff discussing choices and waiting for verbal and implicit consent when supporting women.
- Consent forms we reviewed had been signed and dated for women who had undergone caesareans sections.
- The correct termination of pregnancy notification forms were completed and sent to the chief medical officer as required by the department of health.
- Fraser competency and mental capacity act was considered for young people and vulnerable adults with special needs.
- Staff had received training in mental capacity and deprivation of liberty safeguards.

Are maternity and gynaecology services caring?

Good

Women said midwifery and nursing staff were caring and information about choices was provided in a way they understood.

We observed person centred compassionate care and saw staff responding respectfully to requests for support.

A bereavement midwife was in place to provide additional specialist support for women who had experienced a miscarriage or still birth. Midwives had been provided with facilities and resources to enable them to support grieving families as sympathetically as possible.

Compassionate care

- The national 2014 maternity survey completed by patients showed that this trust achieved better ratings than the national average in areas such as 'attention from staff' and 'communication about care and treatment'.

Maternity and gynaecology

- We spoke to 12 patients and six family members across the antenatal clinic, delivery suite, triage, antenatal/ postnatal ward and gynaecology unit.
- Patients described positive experiences and felt doctors, nurses, health care assistants and allied health care professionals were kind and helpful.
- Women described good eye-contact and simple language was used to aid communication.
- The trust encouraged patients to complete a discharge questionnaire about their experiences and 13 of the 15 forms we reviewed were positive. Where the feedback was less than positive we could see this had been brought to the attention of maternity matron for review.
- During our inspection we observed caring, respectful and compassionate interactions between staff and women and their families, particularly in relation to women attending for termination of pregnancy or who had experienced a miscarriage.
- Midwives had good contact with the registrars so funeral arrangements were as streamlined as possible. Staff made moses baskets in which to place the remains of the termination or miscarriage to make the process less clinical and to help with the grieving process. This was done in keeping with the woman's wishes. Women were also asked how to refer to the foetus following a termination of pregnancy.
- The majority of rooms were single with en-suite facilities and so midwives left a 'visit' card in the patient's room to show a check had been made when the patient had not been in the room. Privacy curtains were used in bay areas where appropriate. This ensured the dignity of women was maintained.

Understanding and involvement of patients and those close to them

- Patients felt their family were involved and that they had been given enough information about test results and what to expect during their stay.
- Birth partners were supported to remain with women in labour. Each room had a reclining chair for their use and access to drinks and snacks.
- Birth partners told us they felt involved in care and treatment. We observed staff involving and supporting family members appropriately.
- Staff recorded the choices made by women in relation to pain control, breast feeding and preparedness for being discharged.
- We witnessed staff explaining care, treatment and processes in easy to understand terms.
- The tone and language used in records to describe care and treatment indicated midwives and doctors had a respectful and caring attitude towards patients.
- One woman felt that when a procedure was cancelled she was not given enough information. She understood that there had been an emergency situation but felt she was not shown care and consideration after the decision to treat had been made.

Emotional support

- Staff considered the emotional needs of women and their partners and this was discussed during the handover of shifts.
- Specialist midwives confirmed their additional training included dealing with the emotional needs of women referred to their services.
- Assessments for anxiety and depression were completed and women were referred to the perinatal mental health team if required. The trust had employed a bereavement midwife who worked 18 hours a week and women were also referred to outside counselling services when this person was not available. The chair person for the maternity service liaison (MSL) committee stated she was involved in plans to develop a bereavement guide.
- Mothers were supported to spend time with their baby if admitted to the neonatal unit to enable bonding.
- The trust had recently developed a care pathway with a local hospice to enable women to spend more time with their baby in a homely environment if it was stillborn.
- There were a number of systems and processes in place to make sure women and families who had experienced a still birth or a miscarriage were treated with compassion and sensitivity. Examples included admission to a separate area away from mothers with their babies, provision of a 'sweet dreams' box which held a camera, teddy-bear, clippers and ink pad so that parents could have pictures, and hair and foot prints as a memento if they wished.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Requires improvement

Access to the midwifery led unit could be limited because midwives were often diverted from the unit to work on the delivery suite if this was short staffed and the times when it was unavailable had not been monitored. On two occasions in 2015, the delivery suite was closed due to insufficient staff and patients were directed to other maternity units.

Interpreters were available for patients whose first language was not English. However, patient information leaflets were not available in any other language than English.

Specialist midwives and processes were in place to support patients with complex needs such as diabetes, learning disabilities, mental health needs or drugs and alcohol dependency issues.

The service was open to suggestions and responded to feedback from people who used the service, other maternity services, commissioning agencies and outside auditors.

Service planning and delivery to meet the needs of local people

- The midwifery service liaison committee is a community based group made of people planning, providing or receiving maternity care. The chairperson of the local midwifery service liaison (MSL) committee confirmed that at least two members of staff from Arrowe Park maternity services regularly attended meetings.
- The MSL chair-person described ways in which the trust had involved the group in planning gynaecology and midwifery services, for example reviewing leaflets and discussing ideas for staff training.
- The service responded to what patients said, for example surveys suggested woman preferred side rooms and so the post-natal ward was reconfigured accordingly. However, some mothers said they felt isolated in side rooms. In response to this senior managers were planning to develop a communal area.
- In response to the NHS England's visit and quality assurance screening report June 2015, the trust had employed a screening programme coordinator.
- The service had established a breastfeeding steering group with good multiagency representation. The group met monthly to discuss and organise breastfeeding initiatives. Representatives included the hospital and community infant feeding coordinators, an independent midwifery service, local authorities and the national child birth trust.

Access and flow

- Bed occupancy rates in maternity were above (worse than) the England average for each quarter of 2014/15, with the exception of quarter four, when the bed occupancy was below (better than) the England average.
- The service could not be confident that patients were able to access the service they wanted because the midwifery led unit was not always available and the times when it was unavailable had not been monitored.
- The consultant led delivery suite was closed in December 2014 and May 2015; senior managers confirmed this was due to staff shortages. We saw that there was a clear protocol and escalation policy which included liaison with other midwifery units.
- We saw that access and flow was discussed at the June 2015 'labour ward steering group' and action taken if a new concern arose. For example problems had arisen because at one time up to nine women had been booked for induction of labour on the same day. We saw that an action plan had been put in place to cap the number of inductions to three on one day.
- The admission processes involved women ringing the maternity unit to go through triage. However, on some occasions, telephone triage was not available and women would be triaged on the delivery suite.
- The trust's target was for 100% of pregnant women referred for antenatal care in their second trimester to be offered a booking within 2 weeks of referral. Between January 2015 and May 2015, this target was only met once, with the worst performance in January 2015 when the target was met for 57.1% of women, however performance improved and the target was met in June, July and August 2015.

- The ward sister for gynaecology was proactive and aware of the needs of the patients and the level of risk on the ward. Although available the ward rarely used agency staff. We observed a calm, well-run unit.

Meeting people's individual needs

- Specialist midwives and processes were in place to support patients with complex needs such as diabetes, learning disabilities, mental health needs or drugs and alcohol dependency issues.
- Interpreter request forms and invoices showed patients had access to these services. The policy was clear when the need was identified and there were no barriers to accessing translation services. The trust was considering how to work with women who wanted their partners to translate for them during booking appointments, recognising that this is not considered acceptable practice.
- Patient information leaflets about gynaecological and obstetric procedures were available in waiting areas. Whilst they included information about how to access them in larger print or braille, they were not available in any other language than English.
- Data indicated that women who presented with acute mental health symptoms were provided appropriate support within 5 working days.
- The service employed community based health care assistants to work under the supervision of a team midwife to provide physical and psychological support to women in the community including support with infant feeding and baby care.
- In the 2013 CQC maternity survey, the trust scored above (better than) the England average for the question 'If you used the call button how long did it usually take before you got the help you needed?'.

Learning from complaints and concerns

- The patient advice and liaison service (PALs) report showed they had dealt with 26 complaints about gynaecology and 17 about maternity. The report indicated that between 1 April 2015 to the date of inspection there had been 10 complaints about gynaecology and 18 about maternity, all had been resolved locally through the hospitals complaint process. The report also noted the complainants had been satisfied with the outcome of the complaint because no appeals had been made to the Parliamentary and Health service Ombudsman (PHSO) for a second opinion.
- We reviewed ten complaints records and saw these had been reviewed by a member of the midwifery management team and appropriate action had been taken.
- The ward manager for the gynaecology unit had completed root cause analysis (investigation) training.
- We reviewed the complaints report November 2013 – January 2015 for the gynaecology unit which showed that complaints were reviewed to identify trends and influence future practice.

Are maternity and gynaecology services well-led?

Requires improvement

The gaps in systems for sharing information, learning from incidents, deploying midwifery and medical staff, and focusing quality audits meant the governance of the maternity services needed to improve so that staff working directly with patients were well informed and supported to maintain the high standard of care.

The system to determine rota's for midwives was not robust and the trust did not always know the level of risk at which the service was operating because the risk management systems such as the ward safety check, incident review and root cause analysis processes were not always implemented correctly.

The senior management team described early plans to review the layout, use of the facilities on the maternity unit, and improve liaison with local community groups. Plans also included a closer working relationship with other maternity services so that effective ways of working could be shared.

Ward staff were aware of the short and long-term goals for the service but did not feel involved in the plans to bring about the changes.

Vision and strategy for this service

- The trust had developed a five year strategy 2014 - 2019 for women and children services. Records showed goals had been set and plans had been reviewed in 2015 and adjustment made to keep plans on track.
- The band 7 midwives, matrons and senior midwifery staff knew about the trusts long-term goals for their areas for example plans to try and increase the number of babies born at the trust.
- The trusts vision was to provide services governed by PROUD values and behaviours. This meant staff were expected to be patient, show respect, take ownership of their actions, act as a team (unite) and be dedicated to meeting the needs of patients. Staff were aware of this vision.
- The vision for maternity services also included the 6 C's outlined in the Chief Nursing officer for England's national nursing strategy 2012. The 6 C's are: care, compassion, competence, commitment, courage and communication.

Governance, risk management and quality measurement

- Risk management of staffing was poor which meant that there were sometimes an insufficient number of staff on the delivery suite based on the acuity of the women receiving care.
- The leadership team had taken action to improve staffing however the management of midwifery staff was disorganised and the system to determine staffing rota's was not robust. This resulted in occasions when midwives were allocated to two separate areas on the same shift. In addition, there were some examples of staff working up to 16 hours in a day, and clinical staff working beyond a point where they felt safe.
- Discussion with the head of midwifery confirmed that senior management team were aware of the problems with the e-rostering system for deploying staff. We were informed about the strategies and protocols for assessing the risk on ward areas, escalating staffing issues and changing rosters. However, our observations during the inspection, feedback from staff and the review of the staffing record for the week of the inspection showed that management of these systems needed to be more robust.
- Comprehensive systems to measure performance were being developed and defined. However, the trust did not always know the level of risk at which the service was operating because the risk management systems such as the ward safety check, incident reviews and root cause analysis process were not always implemented correctly.
- The women and children's division had a number of forums to review and update clinical and operational policies and audits. The role of meetings appeared duplicated. For example the women and children's clinical governance meetings, the obstetrics and gynaecology directorate audit meeting and the divisional clinical governance steering group all reviewed and reported on the same topics.
- The minutes from the women and children's clinical governance meeting in June 2015 showed that the results of audits were discussed and that staff were identified to lead compliance, but no timescales for completion were recorded.
- The minutes from the clinical governance meeting in July 2015 showed that checks were kept on the progress of audits. These minutes also gave a list of new and updated guidelines.
- Information about audits from senior governance meetings was discussed at a unit level 'labour ward steering group meetings', and showed that memorandums, the theme of the week white board and verbal feedback were the main methods of sharing information. The attendance lists for January, April and June 2015 showed however shift leaders did not always attend and there was no evidence that the detail of meetings was fed down to shift leaders to enable them to understand the impact of the outcomes from governance meetings.
- The trust provided job descriptions for each band of staff. Those we talked with were clear about their roles and responsibilities.
- Service level agreements were in place for working with and managing relationships with third party providers such as an independent maternity service.

Leadership of service

- The leadership of the maternity services had changed in November 2014 and the service was being reviewed to make sure future developments met the needs of the population, were sustainable and based on best practice.

Culture within the service

- All maternity and gynaecology staff said they got on well and worked as a team.
- Although gynaecology and maternity are in the same division we found they used different systems at ward and unit level for measuring staff involvement, patient outcomes, review of performance against best practice guidance and development of local policies and procedures.

Public engagement

- We received positive feedback from the maternity service liaison committee chairperson about public engagement.
- The trust used social media to share information with the general public and encourage feedback about the maternity services.
- The trusts strategic plan for 2014-2019 did not include information about how the trust would tell and involve the general public about the plans.

Staff engagement

- In the 2014 NHS staff satisfaction survey the trust came within the bottom 20% in many areas when compared with other trusts. Poor results included whether staff felt involved in making future plans or felt listened to. The results had been broken down into divisions and only 17% of maternity /gynaecology staff who completed the survey felt there was good communication between senior management and staff.
- The women and children's division senior management team told us they were working on unit level staff surveys. This was at the early planning stage and not yet evident in meeting notes and reports provided by the trust.

Innovation, improvement and sustainability

- The midwifery led unit was equipped with two birthing pools and there was also equipment which enabled baby monitoring during a water birth on the delivery suite.
- The community midwives provided a community resource called 'the shop' at the Birkenhead Pyramid shopping centre. It was open five days a week with open access to all women. Women could attend at any stage of pregnancy or postnatal period. At times 100 women visited this service each week.
- Midwives were encouraged to take on specialist roles and work closely with shift leaders and specialist nurses in preparation for staff retirement. The head of midwifery stated the service was trying to attract midwives from other trusts and hospitals so that new ways of working could be introduced. This was seen to be effective in relation to the newly employed foetal screening coordinator.

Services for children and young people

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

Information about the service

The service for children and young people (CYP) consists of a neonatal level three unit, a 32 bedded inpatient ward which houses eight day care beds and an outpatient service. All wards are located in the women's and children service unit, to enable good communication with the neonatal ward and maternity services.

The neonatal unit is a level 3 unit offering care to babies who require intensive or high dependency care. The paediatric ward has two high dependency care beds. Children who require specialist surgery or intensive care are transferred to tertiary services.

The children's emergency department (CED) is open from 9am to 11pm Monday to Thursday and between 10am and midnight Friday to Sunday. The service treated 5,583 children between January–December 2014, 93% of those were emergency admissions. Children requiring the service out of hours are seen in the main emergency department (ED). Between April–August 2015 the service saw 1,220 children out of hours in the ED.

A consultant led paediatric service is provided for children and young people at various locations in the community.

As part of the inspection we visited all areas of the children and young people services; we observed handovers in the neonatal and paediatric wards. We spoke to 13 parents and five patients. We spoke to 30 staff, including five consultants, three doctors, 19 nurses, two domestic staff members and one play nurse specialist.

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

Services for children and young people

Summary of findings

The inspection highlighted concerns with the safety of equipment on the paediatric ward. The resuscitation trolley was not locked and did not have a defibrillator on it. We found expired drugs in the controlled drug cupboard and these had not been removed or replaced by the pharmacist. Our concerns were immediately raised with the trust during the inspection and actions were undertaken to rectify them.

We found that the safeguarding policy did not refer to current guidance and there was no monitoring tool to identify the knowledge and understanding of the safeguarding training after staff had received it. We identified several gaps in the documentation of safeguarding case notes such as incomplete MARS (Multi Agency Referral Service) forms. The electronic patient file did not have any statutory flag that alerted staff who were reviewing the case notes that it contained information relating to a safeguarding concern.

The neonatal unit had previously denied the admission of babies due to limited cot space on the neonatal unit and the cot space did not meet the British Association of Perinatal Medicine (BAPM) standards.

The community paediatric service consistently failed to meet national referral to treatment targets and the waiting list was lengthy with some children waiting up to 47 weeks. However, services for children at Arrowe Park Hospital consistently met the national referral to treatment targets.

The service did not have a transition policy in place and nursing staff were unclear how to initiate a child's transfer to adult services in line with guidance.

The systems in place to determine staffing numbers on the paediatric wards were not robust and we found that the service lacked visible trust leadership; however local management of the wards and children's assessment unit (CAU) were supported by enthusiastic consultants and senior ward staff.

There were governance structures in place which included a risk register. Some risks on the register had been there since 2012 and 2013 with actions still being completed.

Care on the neonatal unit was well managed and local leadership on the unit was clear and directive. It was evident from examples such as a parent led discharge plans and informal huddles that the neonatal unit constantly looked at ways to improve care. However, at service level, there was limited evidence of how the quality of care given to children and young people was being measured and how the information being gathered was used to improve the service.

Parents and young people felt safe and informed about their treatment. We observed children being looked after with respect and dignity. We observed good hand hygiene, staff washed their hands between patients and used aprons to reduce the risk of infection spreading.

The children and young people's service participated in nine national and local audits in 2014/2015. Results of these audits were within the national average and the service had implemented improvements in neonatal practice, home ventilation and hand hygiene practice, feedback and recommendations.

Communication was good amongst medical and nursing staff; this was evident during ward rounds and handovers. Appropriate consent taken from parents and patients before any care or treatment was given and records were updated to reflect this.

Food and hydration intake was monitored regularly by nursing staff and this information was recorded in the child's care plan.

Services for children and young people

Are services for children and young people safe?

Requires improvement

The inspection highlighted concerns with the safety of equipment on the paediatric ward. The resuscitation trolley was not locked and did not have a defibrillator on it and entries in the log book were inconsistent. We found expired drugs in the controlled drug cupboard and had not been removed or replaced by the pharmacist. Our concerns were immediately raised with the trust during the inspection and actions were undertaken to rectify them.

We found shortfalls in the way safeguarding cases were reviewed and managed. We reviewed the patient pathway and found that the electronic patient file did not have any statutory flag that alerted staff who were reviewing the case notes that it contained information relating to a safeguarding concern. We found no clear method of monitoring safeguarding training and there was no mechanism in place to check staff knowledge and their level of understanding following any training they received. Safeguarding documentation was incomplete and the information had not been appropriately cascaded to all necessary staff in the three cases we tracked.

Staff knew how to report incidents but did not always know what constituted an incident. When incidents were reported, they were investigated and lessons learnt were shared through huddles.

There was no recognised acuity tool in use to determine staffing numbers. A band 6 nurse devised the staff rota and the skill mix of each shift was based on their knowledge of individual staff competencies. The paediatric ward had previously closed due to concerns that the ward did not have the right numbers of staff or skill mix for the acuity of patients.

The neonatal unit had previously denied the admission of babies due to limited cot space on the neonatal unit and the cot space did not meet the British Association of Perinatal Medicine (BAPM) standards.

Nursing and medical handovers were comprehensive containing detailed information about the children in their care. Medical records were clear, legible and concise. All case notes were stored securely, showed regular involvement from medical staff, nurses and pharmacists. There was evidence of clinical investigations being followed up by both medical and nursing staff.

All areas we visited were visibly clean and well maintained and the rates of hospitals acquired infections were low across the service.

Incidents

- Incidents were reported centrally through an electronic reporting system. The service reported 142 incidents between March and June 2015. However, it was evident that staff did not always report incidents. For example, we had to prompt staff to report incidents during the inspection because they did not realise that what had happened constituted an incident.
- The neonatal and children's ward reported 27 medication errors between January-June 2015. When incidents were reported, staff were confident that they learnt from them. As an example, it was identified that some medication errors had occurred due to illegible handwriting. To reduce the risk of recurrence, doctors were asked to complete all documents correctly and in legible handwriting. Medical staff viewed this feedback as constructive and nursing staff told us the standard of documentation had improved.
- Lessons learnt from incidents in the neonatal unit were cascaded through "huddles". These took place on a weekly basis and were informal. As part of the huddle, staff brought solutions to problems they had experienced during the week to share learning amongst colleagues. In addition, learning from incidents was communicated to staff on the notice board in the unit.
- Staff understood the significance of complying with the duty of candour regulation and were aware of the trust's policy. Staff in the neonatal unit were well informed about the process they would follow in an event where a mistake took place in the patients care.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean and tidy.
- Data provided by the trust showed that the paediatric ward had not recorded any cases of clostridium difficile or MRSA infections between January and May 2015.
- In the neonatal unit, the results of hand hygiene audits illustrated 91% compliance and were clearly displayed on the notice board for visitors to view.

- Staff uniforms were visibly clean and all staff followed the 'bare below the elbow' guidance.
- Staff adhered to current infection control guidelines. We saw staff washing their hands using the appropriate techniques between patients and using hand gels where appropriate.
- Personal protective equipment was readily available, including gloves and aprons. We saw staff wearing them where appropriate.
- Arrangements were in place to manage waste and sharps bins safely. Disposal waste bins were clearly labelled.
- Cleaning schedules were used to ensure the environment and equipment was clean throughout all wards. They were regular checked and signed by staff.
- In the play area in the children admissions unit, toys were visibly clean and well maintained.

Environment and equipment

- All children's wards we visited had secure entrances, which were monitored by staff. Visitors could only enter the ward after they had confirmed who they were visiting. Wards were only accessed by entry phone or swipe card. However, during our visit we found the reception desk unattended on several occasions and at times we waited more than five minutes to enter the ward.
- Records indicated that a resuscitation trolley inspected on the paediatric ward was not checked regularly. The trust's policy indicated that the trolley should be checked every day by nursing staff. The log book showed entries in December 2014, then in May 2015 and July 2015. Part of the safety checks included checking the contents of the resuscitation trolley to ensure the correct equipment was available and items were in date. There were several items on the trolley that had expired such as a cannula, brite blades and saline. In addition, there was no defibrillator present. This was against best practice guidelines which state that a working defibrillator must be available. This was brought to the attention of staff immediately and they took steps to rectify the situation. However, they did not recognise this as a reportable incident and did not report this until prompted to by inspection staff.
- We saw that equipment on both wards had not been PAT (portable appliance test) tested. The requirement under the Electricity at Work Regulations (1989) state that equipment should be checked and maintained to prevent risk. For example, we noted a fan had been last tested in 2010.
- Wall sockets on the paediatric ward behind beds did not have plug protectors in them, and were within reach of children on the ward. The ward manager on both the neonatal and paediatric unit were alerted to this and advised us that they would arrange an appointment with estates to rectify this.
- Neonatal ward staff were all aware of current guidance such as British Association of Perinatal Medicine (BAPM) guidance, they told us the unit had closed to admissions previously because of the lack of cot space and nurse staffing. This was corroborated by incidents reported between March and June 2015. The cot space in all three rooms on the neonatal unit was limited. This issue was recorded on the risk register and the clinical lead advised that a full costings bid for financial support to extend the unit had been submitted to the capital bid programme in September 2015 for consideration for 2016/2017.
- There were two play areas on the paediatric ward, one for 0-8 years and another for 8-16 years. There was also a sensory room although this was temporarily closed for repairs at the time of the inspection. These rooms were not in view of any nurses' stations. However, the trust told us that there would always be a nurse/play leader, CAMHS worker or parent with the child or young person when in these rooms.

Medicines

- Medicines were stored securely and out of reach from children. Staff were aware of the controlled drugs policy; the controlled drug cupboard was accessed by a limited number of qualified nurses and was locked at all times. The key to the cupboard was held by the ward manager or matron.
- At the time of our inspection, the controlled drug cupboard in the neonatal unit contained expired drugs. We notified the ward manager and the drugs were removed by the pharmacist. Pharmacist records of the disposal of expired drugs from the controlled drugs cupboard on the neonatal ward showed entries from July 2015 but none subsequent to this until the date of the inspection.
- The drugs log book held in the neonatal ward was checked for accuracy and we found one incident where

medication was incorrectly recorded. The Controlled Drugs (Supervision of Management and Use) Regulations (2006), states all records of controlled drugs must follow guidelines; records should be accurate and concise. We prompted staff to report this as an incident.

- Following a listening event, parents and carers indicated that they wanted more involvement in managing their child's medication. As a result, the medicines management team decided that low risk medicines such as Gaviscon sachets, sodium chloride 0.9% nasal drops and salbutamol inhaler could be prepared by a nurse and administered by a parent/carer. This was being promoted by staff on a trial basis. We were told the results of this trial would be fed back to the medicines management panel to decide if the practice would continue.

Records

- We reviewed 15 case notes. Care plans contained evidence of daily discussions between staff and parents. Records in the neonatal ward were clear, legible and concise. The case notes all recorded the child's full name, date of birth, weight and family history.
- All case notes were stored securely, showed regular involvement from medical staff, nurses and pharmacists. There was evidence of clinical investigations being followed up by both medical and nursing staff.

Safeguarding

- There was a safeguarding policy in place and a trust wide safeguarding team who operated Monday – Friday, 9am - 5pm. However, there wasn't a paediatric nurse as part of the safeguarding team, which is recommended as best practice in the Royal College of Paediatrics and Child Health (RCPCH) guidelines 2014.
- Staff understood the referral process for suspected child abuse and were aware of the safeguarding team and policy. Staff could direct the inspection team to the referral forms they used when they were concerned about a child's safety. There was clear information about child abduction and staff were aware of how to escalate their concerns.
- We saw MARS (Multi Agency Referral Service) forms that were partially completed. The forms were sent to the trust wide safeguarding team but there was no evidence to show that the team queried missing information on the form.
- We looked at three patient case notes where there were safeguarding concerns. They contained limited information about the safeguarding concern.
- The safeguarding children and child protection protocols did not meet best practice guidance in a number of areas. The safeguarding policy was updated in December 2014, and referred to "working together 2004" but no reference was made to the more recent guidance "working together 2010 or 2014" which were both available at the time the policy was revised. The policy referred to definitions of abuse taken from old guidance 'working together' (2006). In addition, the safeguarding policy did not promote multi agency working which is key in child protection protocols, for example there was no mention of notifying school nurses of a referral.
- The safeguarding training strategy had not been revised since 2009 and was not compliant with Royal College of Paediatrics and Child Health (RCPCH) guidelines 2014, which states that professionals should receive up to a minimum of 3 - 4 hours of safeguarding training every three years. However, staff are required to complete training every three years but only receive two hours of level 2 safeguarding training. In addition, safeguarding level 1 training was a basic overview of safeguarding vulnerable groups of people such as children. This was included in mandatory training as a 30 minute presentation and supplemented by a safeguarding information booklet instead of the recommended two hours.
- All staff received a booklet on safeguarding, as a basic introduction to safeguarding and the expectation was that staff read the booklet in their own time. Staff were asked to sign upon receipt of the booklet to confirm they had received it. However, there was no monitoring tool in place to ensure staff had read and understood the content of the booklet. Overall, 96% of medical and dental staff and 77% of nursing staff received the booklet
- Safeguarding level 2 training data was provided, which showed that no nurses had completed it but 77% had completed level 3 safeguarding training. There was no monitoring tool in place to assess the understanding of the training provided.
- Audit programmes or monitoring tools that audit the number of children who attend the emergency department with safeguarding concerns were not available. This is because there was no system in the

emergency department to identify safeguarding concerns once a child had been admitted to the ward or discharged home. The IT system allowed staff to summarise the detail of any safeguarding concern in the notes of the patient's electronic file. The information could then be accessed throughout the patient's journey in the trust; however the system had no statutory tick boxes ensuring the information had been or needed to be read. If a medic or nurse was reviewing the patients information there was no identifier such as a red flag alert to direct the reviewer to look at the information in the notes. The safeguarding logging system in the emergency department was dependent on how familiar the reviewer was with the system.

Mandatory training

- Mandatory training was provided in two 'blocks'. Block B was a rolling 18 month programme and included training on areas such as infection control. Block A training was provided on a three year rolling programme and this covered subjects including safeguarding and manual handling.
- Mandatory training figures showed that 70% of staff had completed all training, both Block A and B; however, this was below the trusts own 95% target.

Assessing and responding to patient risk

- We were shown three different paediatric early warning scores forms, which were categorised by age. We found no supporting protocols stating times at which staff should use them. We found no trigger system or protocol to inform staff when to escalate a deteriorating patient on the ward.
- There was no dedicated anaesthetic rota for children; the consultant anaesthetist oversaw critical care for children whilst the general on call anaesthetist registrars saw children when required on the ward.
- The neonatal consultants at the trust had links to the neonatal transport team to ensure arrangements to transfer children to another tertiary hospital were seamless. Any change to the transport protocol was quickly cascaded through both teams via consultants to avoid any problems. Both the neonatal and paediatric ward were efficient at transferring a child, the preparations were managed well.
- Staff were observed communicating with tertiary centres to ascertain how children that had been transferred were progressing.
- The paediatric ward did not use a safety thermometer but monitored outcomes for patients and infections through a dashboard.

Nursing staffing

- There was no recognised acuity tool in use to determine staffing numbers on paediatric wards. A band 6 nurse devised the staff rota and the skill mix of each shift was based on their knowledge of individual staff competencies.
- We were informed that the team had nurses with limited experience of high dependency and mental health care. The staffing team on the paediatric ward consisted of one nurse who had a mental health background and one HDU trained nurse. The knowledge on the remaining team was limited and no provision was in place to cover these nurses having annual or sickness leave.
- In the previous six months there were occasions when staffing on the neonatal ward did not meet British Association Perinatal Medicines (BAPM) standards. In Jan (48%), Feb (35%) and Mar 2015 (13%) nursing shifts did not met BAPM standards, however during the inspection the ward was fully staffed.
- We observed a nurse hand over, which was specific and detailed. Nurses informed each other about priorities and used bed numbers instead of patient names to protect identities of the patients they discussed. The information was well received and senior nurses were happy to support and advise the less experienced nurses.
- The paediatric ward had vacancies for band 5 and band 6 nurses at the time of inspection. Shortages of staff were covered by bank and agency staff. The bank staff included ex-staff members who were familiar with the trust policies and the way the ward operated.
- When agency staff were used, the ward operated on a buddy system to ensure agency workers were supported. Competencies were discussed and workers are placed in areas they are comfortable in.
- The paediatric ward was closed in March and June 2015 due to low staff levels, both bank and agency staff could not fill the shortfall in staff on those occasions.
- The CAU had two nurse specialists on the ward after 5pm. Overtime was frequently given to staff on the CAU

(children's assessment unit) to ensure the unit was fully staffed. The trust was recruiting nurses to work on the CAU at the time of the inspection with a view to filling one vacancy.

Medical staffing

- There was a good skill mix in the children's and young people's service. There was a higher proportion of consultants in this service than the England average; however, there was a lower proportion of junior and middle grade doctors.
- There were two doctors on the CAU after 5pm. In addition, on call consultants were on site until 8.30pm in Winter months and 7pm in Summer months. Outside of these times, consultants were available on call.
- Medical handover on the neonatal ward was succinct and informative. A good example of effective communication between departments was seen during handover. The matron discussed information about a complex delivery with the neonatal team and explained how it may result in neonatal admission she also planned to liaise with the maternity unit regarding an incident that occurred overnight. She planned to attend their staff meeting to discuss the lessons learnt to prevent the incident from recurring. The consultant gave clear direction about the roles of the doctors for that day and updated the team about the current situation of the unit, for example information about transfers and visitors to the unit.
- Data provided by the trust showed that wards used a low number of medical locums. The neonatal ward reported 24 medical locum shifts between January 2015 – March 2015 and the paediatric ward reported 88 medical locum shifts between January 2015 – May 2015.

Major incident awareness and training

- Staff were aware of the major incidents policy, the policy states that all departments have an action card that must be followed in an event. However, not all staff were aware of where the action card was kept in the department. Senior staff confirmed that the action card could also be found on the intranet.
- There was little evidence of the CYP services planning for anticipated problems. Staff relied on guidance from senior managers about how to deal with unexpected situations. For example staff told us that a sudden influx of patients during the bronchiolitis season inundated the service with poorly children. Staff escalated this to the consultant and the hospital coordinator and as a result the play area on the ward was turned into a 6 bedded area to accommodate the high volume of patients.
- The trust had a hazardous materials policy, a flood plan, and a heat wave plan. Staff were not aware of the different policies or trigger points associated with them but knew that they were available to access on the intranet.

Are services for children and young people effective?

Good

The children and young people's service participated in nine national and local audits in 2014/2015. Results of these audits were within the national average and the service had responded well to the findings by carrying out actions to improve practice.

Communication was good amongst medical and nursing staff; this was evident during ward rounds and handovers. Appropriate consent taken from parents and patients before any care or treatment was given and records were updated to reflect this.

Food and hydration intake was monitored regularly by nursing staff and this information was recorded in the child's care plan.

The training and development of staff on the paediatric ward we visited was not a priority and staff did not feel they were supported to develop themselves. Staff felt that this hindered their progression and clinical ability to care for patients with specialist needs such as high dependency patients and those with mental health needs. Data provided by the trust confirmed a third of the staff had not received their annual appraisal.

Policies and guidance on the trust intranet contained links that did not work.

Evidence-based care and treatment

- Care and treatment was delivered in line with evidence based practice and national guidance such as National Institute for Health and Care Excellence (NICE) guidance and British Association of Perinatal Medicine (BAPM) guidance.

- A local audit was carried out and reported at the paediatric audit meeting in March 2015. The audit looked retrospectively to review the adherence to local neonatal sepsis guideline which was developed from NICE guidance CG-149 relating to antibiotic therapy for early onset neonatal sepsis. The results highlighted that 80.2% of neonates had received antibiotics within an hour of the decision to treat but the reason for delays in administering antibiotics were not always documented. The audit highlighted a high level of compliance with other key indicators and an action plan had been developed to improve. The trust planned to re-audit this after 12 months to identify if improvements had been made.
- Care plans were in place in the records we reviewed and staff were aware of the importance of keeping children and their families informed about any changes or updates to them.
- An advanced care plan specific to end of life care for a child in the children's assessment unit (CAU) was out of date and no copies of the plan were available in the main emergency department posing a risk that the wrong course of treatment could be followed.
- Several policies relating to cot death, and respiratory airways were available on the trust intranet. However, they contained various links for staff to use but some of the links did not work.

Pain relief

- Patient notes showed that ward staff used a tool to assess pain in young people. The tool was child friendly and included ladders and used a smiley face theme.
- Nurses were confident in assessing pain and it was evident from discussions we observed that managing pain was a priority. We noted that children and young people received pain relief in a timely manner. This was documented in the notes we reviewed.

Nutrition and hydration

- Records indicated that food and hydration intake was monitored regularly by nursing staff. Patients were asked about their water intake and their food preferences. This information was recorded in the child's care plan.
- Four children told us things about the food such as "it wasn't too bad" but "it could get boring if you were in hospital for a long period of time". They felt more could be done to make the menus more age appropriate and appetising.
- Domestic staff were friendly, we saw them speak to the children about their menu choices. Staff were aware of the drinks protocol and told us that the trust catered for patients who had special dietary requirements such as kosher and gluten free diets.
- The trust provided food for mothers who were breastfeeding and there was an out of hours food service for children. Nurses also told us light snacks such as toast were always available to children on the ward.

Patient outcomes

- The trust participated in nine national and local paediatric audits, in 2014/15.
- The diabetes audit showed a lower prevalence of controlled diabetes 10.4% compared to the national average of 17.1%. The paediatric ward had three audits that were overdue, including, an audit of safeguarding, audit of methadone ingestion and patient satisfaction survey for constipation. Staff explained that the outstanding audits needed to be reassigned to another doctor as the one who was leading them had left the trust.
- The neonatal unit had two audits that had not been carried out. This was because case notes were not available. The audits had been highlighted on the CYP audit register and case notes had been requested.
- In the 2014 CQC Children's survey, the trust scored about the same as other trusts in four of the six effective indicators, which included the question "Do you think the hospital staff did everything they could to help ease your child's pain?". The trust also performed better than other trusts for two indicators which included the question "Were the different members of staff caring for and treating your child aware of their medical history?".
- Nurses had organised a monthly journal club, which was also attended by student nurses. The club was a forum for nurses to review cases and share learning.

Competent staff

- The staffing skill mix on the neonatal unit met British Associate of Perinatal Medicine (BAPM) standards. There was a good skill mix of level 1, level 2 and level 3 neonatal nurses on the staffing rota.
- Medical staff received protected time for training, which took place between 8.15am - 9am Monday to Friday. A grand round took place every Thursday afternoon, which was attended by staff from the neonatal unit, general paediatrics and community paediatrics.
- Nursing staff were given time to complete mandatory training but other courses were not promoted. We asked eight nurses about their personal development, they all told us that they were not supported, and training courses often got cancelled due to ward commitments.
- Training opportunities were limited because training time was not protected and staff shortages meant that staff could not be released to attend courses. At the time of the inspection, the service did not have a person responsible for identifying and leading on training within the department. There was no system in place to identify the learning needs of staff. The staff we spoke to confirmed they needed more guidance and development opportunities to enhance their skill set.
- We were told end of life training was not part of mandatory training and that nursing staff would take direction from the consultant's if a child was for palliative care. There was no evidence of palliative team input on the ward.
- The trust provided us with data on appraisals; 32% of nursing staff had not received an annual appraisal. However all medical staff had received an appraisal as of August 2015.

Multidisciplinary working

- We observed a ward round on the neonatal unit. There were good interactions between the consultant and registrar. Medics discussed patients' needs and treatment and took advice from nurses regarding the babies feeding.
- Neonatal unit discharge planning was led by the consultant, and involved a multi-disciplinary team. They discussed the progress of the baby and competence of the parents before discharge was agreed
- There were weekly multidisciplinary team meetings. These included the safeguarding team, neonatologists and physiotherapists. The meeting was used as an open forum to discuss each patient's care and identify if any transfers or discharges needed to be planned.
- The service had good links and inter-trust working with neighbouring trusts. We saw good examples of working with another trust to transfer a baby who needed an operation. Nurses and consultants told us they had a good working relationship across the North West and Wales. We observed nursing staff arranging two transfers to another hospital during the inspection. Both cases were managed well and were timely. All six consultants in the neonatal unit also worked for the regional network in the neonatal transport service.
- Input from the children and adolescent mental health service (CAMHS) team was only available Monday - Friday. Nurses said they were confident in calling the team for advice and made regular referrals.

Seven-day services

- The majority of services for children were provided 7 days a week. However, access to the CAMHS and safeguarding teams were only available Monday – Friday with no out of hours service available during the evening or at weekends.
- The service had access to laboratory and radiological services 7 days a week.

Access to information

- The trust used an electronic computer based patient record system which enabled staff to monitor patients remotely across the hospital. If nursing staff alerted medics of a concern, doctors were able to access and review the records anywhere in the hospital so that they could make an informed decision about the patient's clinical needs.
- We reviewed one advanced care plan in the CAU; we found no evidence of the information on the care plan being transferred to the receiving ward. Staff we spoke to were unsure of how to use these forms.
- Records reviewed in the neonatal ward were clear and complete. All information such as test results were available in the case notes and they were clear and legible, making the information easy to access.
- On the paediatric unit, parents and patients were involved in their discharge; doctors explained medication and treatment fully before patients went home. When staff provided patients with take home medication on discharge, copies of their discharge summaries and information about the medication were given to the patient and their carers.

Services for children and young people

Consent

- Staff understood their responsibilities to use the Gillick competencies to determine whether a young person was able to consent and understand the care and treatment that was offered to them.
- Staff ensured that all issues about consent to care and treatment were recorded in line with trust policy, which was supported by records that we looked at.
- Staff were aware of the importance of ascertaining consent in a child friendly way as well as obtaining consent from the patient's parents. Children told us that nurses and doctors always explained any treatment they were going to carry out before they proceeded.
- We saw consultants obtain verbal consent from children. Before they discussed the patient's care or treatment, they explained medical terminology and ensured both the parent and the patient fully understood.

Are services for children and young people caring?

Good

We observed good care on the neonatal ward. Nurses showed compassion and empathy whilst interacting with parents and their babies.

Parents confirmed they felt their child was safe and cared for with dignity and kindness. This was corroborated with the efforts of the staff to continuously improve their service. All parents we spoke to on the neonatal ward said they could not fault the care their baby received.

Parents on the children's ward and children's assessment unit (CAU) described staff as being passionate about the care they gave and tried their best to accommodate any requests they received from families and their patient. Parents' feedback was that the care was excellent but felt the ward was stretched due to staff shortages and as a result staff couldn't offer extra support when needed.

Compassionate care

- Throughout our inspection, we observed children, babies and their parents being treated with sensitivity, understanding and respect.
- We spoke to five children on the paediatric ward who told us they felt safe and comfortable. We spoke to four parents who all said their child had been treated with compassion, dignity and respect. They described staff on the ward and on the children's assessment unit (CAU) as being passionate about the care they gave and said they tried their best to accommodate any requests they received from families and children they were caring for.
- On the neonatal ward, all parents said they could not fault the care their baby received. Staff worked alongside parents to prepare them for taking their babies home. A discharge chart on the board in the step down ward allowed parents to visualise the steps they needed to complete before their baby was discharged. These steps included; bathing the baby, feeding the baby etc.
- There were two play specialists on the ward who worked across the paediatric ward and the children assessment unit (CAU).

Understanding and involvement of patients and those close to them

- Parents said they had received good information about their child's treatment or condition. Parents said that nursing staff were approachable if they did not understand any medical terminology. They had also received sufficient information prior to the treatment, surgery or discharge.
- Children said they had been involved in their care and said that nurses and doctors talked to them about their treatment.
- Three children told us that doctors spoke to them about their plan of treatment and that they felt they could ask questions. They also said that medical terminology was explained to them.
- Parents were happy with the 'open visiting' policy. They were able to come and stay with their child and remain at their bedside, and they appreciated that the nurses worked around them and included and consulted with them about their baby's care. One parent in the neonatal unit said having open access to the ward meant she could manage home life and the other children.

Emotional support

- Parents received emotional support from the nursing staff. Staff listened and responded to parents' anxieties

in a sensitive manner. However, some parents told us that the care was excellent but felt the ward was stretched due to staff shortages and as a result staff couldn't always offer extra support.

- Parents said they felt confident in leaving their child in the care of the staff on the ward. The staff were attentive and helpful; we observed them attending to children in a caring and conscientious way.
- Parents and children both developed trusting relationships with staff and received the support they required to manage emotional strains during treatment and inpatient stay.
- The service offered bereavement support and leaflets on bereavement services were available to parents and families. Staff were aware of them and could sign post parents if needed.
- Staff offered support and help to parents, staff helped one parent organise accommodation at the hospital, so that she could look after her family between visiting her baby.

Are services for children and young people responsive?

Requires improvement

The service was not consistently responsive to the needs of children and young people in the local area.

The children's emergency department (CED) opened until 11pm weekdays and until midnight on a weekend. Thereafter, children were directed to the main emergency department for treatment, which was not best suited to the needs of children and adolescents.

The service did not have a transition policy in place and nursing staff were unclear how to initiate a child's transfer to adult services in line with guidance.

The services for children at Arrowe Park consistently met the national 18 week referral to treatment targets. However, the community paediatric service consistently failed to meet national 18 week referral to treatment targets and the waiting list was lengthy with some children waiting up to 47 weeks for treatment.

The service had provisions in place to meet the needs of their patients such as hospital at home; this service allowed patients to have long term ventilation at home as part of the community service.

The service offered accommodation facilities both on the ward and in Ronald McDonald house, which was on site for parents if they needed to stay overnight. The paediatric ward provided separate play areas for all ages.

Staff on the neonatal unit worked hard to make sure babies and their families had a seamless transfer to tertiary centres when a baby required specialist treatment.

Staff on both wards were receptive to their patients needs'; staff were fully aware that at times things went wrong and said they welcomed feedback to improve their practice. Staff knew what the complaints procedure was and said they would try to resolve the complaint before escalating it to the next stage.

Service planning and delivery to meet the needs of local people

- Children, young people and their families were not involved in the design and the running of the service. Clinical leads confirmed that they did not have a young person's group and did not seek advice from families using the service.
- The entrance to the children's ward was dull and not child friendly, it did not have any child friendly signage or coloured pictures. Children and adolescents were not separated on the ward. However, we did note that there were two separate areas for children and adolescents to play.
- The area for children aged 0 - 8 years old was colourful and all toys were in good working order. Another room for 8 - 16 year olds was available and contained games consoles, board games, a television and other age appropriate equipment. The room was only available to young people aged between 8 – 12 years old when accompanied by a person over the age of 16. However, we were told games and iPads for children aged 8-12 years old were available on the ward at the nurses' station and available on request.
- The paediatric ward had side rooms but these were mainly used for children who needed isolation following an infection or children who were recovering from surgery.

Services for children and young people

- Staff confirmed that the ward did not have separate areas for girls and boys.
- The trust offered an under 16 sexual health clinic on site which was commissioned by the clinical commissioning group (CCG) and ran several times throughout the week.
- The children and young people service had a clear policy on failure to attend appointments. The policy defined steps that staff must take when a child failed to attend an appointment. Staff were all aware of the policy and in the outpatients clinic staff referred to GP's as their next point of contact when a child had missed an appointment.
- The children's emergency department (CED) opened from 9am – 11pm Monday to Thursday and between 10am – midnight, Friday – Sunday. Children who attend out of hours were seen in the main emergency department. During April – August 2015 the service saw 1,220 patients out of hours.
- The trust provided facilities for parents who needed to stay overnight or for long periods of time when their child was an inpatient. Parents and their families who required long periods of stay were offered accommodation at the Ronald McDonald House. Parents told us they were pleased with the support staff provided. They commented that staff were attentive to their child's needs overnight.
- The care at home for ventilated patients was provided by the Continuing Care Team. In addition, the Hospital at Home team provided short term support following acute illness. This team had been operational for more than 15 years across the Wirral.

Access and flow

- The trust consistently failed to meet the 92% target for children to be treated within 18 weeks in the community from January 2015 – August 2015. The performance deteriorated every month from January 2015, when the 18 week target was met 90.8% of the time to August 2015 when it was only met 60.5% of the time. Some children had been waiting 47 weeks for treatment at the time of the inspection. However, we were told that these were routine referrals and urgent referrals were prioritised and seen in a timely manner. We were told that there were no urgent referrals waiting over 18 weeks and the trust told us that a service review was underway. Clinical leads expressed concerns about the lengthy waiting times.
- In contrast, between January 2015 and May 2015, the trust consistently achieved above the national target of 92% for children to be treated within 18 weeks at the hospital. The highest was in February 2015 when the trust report 99.8% of children seen within 18 weeks and the lowest was 96.1% in May 2015.
- Consultants confirmed that the service prioritised care treatment for children with urgent needs. The multidisciplinary meetings gave consultants the opportunity to discuss patients and prioritise their treatment needs.
- The paediatric ward had a designated area for day case surgery. This area was located to the rear end of the ward and was known as the 'yellow area'. Patients that required an overnight stay due to complications during their procedure were transferred to the main ward. Staff worked collectively to admit the patient to the ward in a timely manner to prevent any delays or waiting times after a day case procedure.

Meeting people's individual needs

- The trust did not have a transition policy for children of a certain age who would be due to transition to adult services. We were told that patients of a transitional age were assessed on a case by case basis by the consultant who would co-ordinate their transfer to adult services. However, there was no input from play specialists to support the transition and nurses were unfamiliar with how to support the transfer of a child to adult services.
- The child and adolescent mental health service (CAMHS) was available Monday – Friday. The trust did not offer any weekend service and therefore patients admitted on a Friday night would remain on the ward until they were seen on Monday without being assessed. This was particularly difficult when staff were caring for children who needed specialist or post self-harm review. Patients that required CAMHS input would often be placed under the care of the paediatric nurse who had a background in CAMHS.
- We listened to three parents of babies in the neonatal unit describe their experiences on the neonatal unit, and all highly recommended the care they received. One parent received help with accommodation, which made visiting with other children easier. Another parent found the processes in place for planning their child's discharge was very supportive. They felt supported throughout their journey.

Services for children and young people

- There were good provisions in place to support parents such as a 'neomates' meeting group to help parents plan their baby's care at home and building skills such as bathing and feeding.
- Parents of children staying for long periods of time had access to a kitchen; hot drinks could be made but not taken to the bedside.
- Where patients and their families did not speak English as their first language, staff used language line. Ward staff who spoke a second language told us they could communicate with families whose first language was not English if they needed to.
- There was a sensory room in place to help children with sensory needs. However, it was temporarily closed for safety reasons at the time of the inspection to allow for repairs to a piece of equipment.

Learning from complaints and concerns

- The service received two complaints between January 2015 to June 2015. We were told a 'lessons learnt' discussion was held for each one during staff meetings. The meetings were not minuted but staff informed us that complaints were always followed up with a lessons learnt discussion. We asked eight staff nurses and two consultants how they dealt with complaints; they were all confident with the process and knew how to escalate the complaint where necessary.
- On the paediatric ward there was no signage to inform patients and relatives how to make a complaint and there were no leaflets displayed for patients to provide feedback on the service.
- The neonatal unit asked parents or relatives to complete an electronic survey, using nationally agreed questions and the friends and family test. The feedback was used to improve the service. As an example, the unit had introduced a way of including parents in their babies' discharge by introducing a discharge plan that parents must complete before being discharged. This was introduced as a response to feedback received from parents. In addition, a discharge board was visible on the ward allowing parents to visualise their baby's progress. It included headings such as bathing baby.
- There was a parent group on the neonatal unit at the hospital, and staff would consult with the group to check if any new literature was user friendly.
- Paediatric ward staff were unsuccessful in making 'Fabio the Frog' part of practice, Fabio the frog was an interactive tool designed to obtain feedback about the service in a fun way for children. At the time of the inspection, use of the feedback tool was intermittent and we could not obtain any details of the feedback from it.

Are services for children and young people well-led?

Requires improvement

The trusts vision and values were visible on notice boards across the wards. All staff we spoke to were familiar with the trust's vision. However, staff on the paediatric ward felt constrained by lack of resources to fully work to the vision. The service had a local vision but not all staff on the paediatric ward were familiar with it.

Ward staff felt that they did not have the resources and support to improve their service through carrying out and acting on audits. The neonatal unit business case to increase cot space would not be determined until 2016.

There were governance structures in place which included a risk register. However, some risks on the register had been there since 2012 and 2013 with actions still being completed.

The systems in place to determine staffing numbers on the paediatric wards were not robust and we found that the service lacked visible trust leadership; however local management of the wards and children's assessment unit (CAU) were supported by enthusiastic consultants and senior ward staff.

Care on the neonatal unit was well managed and local leadership on the unit was clear and directive. It was evident from examples such as a parent led discharge plans and informal huddles that the neonatal unit constantly looked at ways to improve care. However, at service level, there was limited evidence of how the quality of care given to children and young people was being measured and how the information being gathered was used to improve the service.

There was evidence of public engagement in the neonatal service. However, there was limited evidence that this had happened across the rest of the children and young people's service.

Services for children and young people

Staff were proud to work for the service and were committed to providing high quality care to the children and families using the service. Junior doctors and nurses received support and felt that the consultants were supportive.

Vision and strategy for this service

- Staff were aware of the trust's vision and values; we saw the trust vision on the notice boards on both wards. However staff on the paediatric ward felt constrained by lack of resources to fully work to the vision.
- Staff in the service were aware of the Chief Executive and the Director of Nursing but did not know who other board members were.
- Not all staff were familiar with the vision for the service, particularly on the paediatric ward. Staff informed us that they were updated about changes to the trust through the matron's communication and emails.
- Staff were proud to work for the service and committed to providing high quality care

Governance, risk management and quality measurement

- The risk register highlighted risks across children and young people's services. Actions were in place to address concerns for example failure to meet National Institute for Health and Care Excellence (NICE) guidelines. However, we were not assured that risks were being managed appropriately as there were risks on the register since 2012 and 2013 with actions still being completed.
- The systems in place to determine staffing numbers on the paediatric wards were not robust and they were not based on any assessment of acuity of children on the wards. We were told that the numbers were determined by a band 6 nurse based on their knowledge of individual staff competencies.
- Children's services meetings had been stopped. These meetings were previously used to discuss how to improve the service. Clinical leads said they had found these useful with regard to service improvement however they had not looked to getting these reinstated
- Care on the neonatal unit was well managed and it was evident from examples such as a parent led discharge plans and informal huddles that the neonatal unit constantly looked at ways to improve care. However, at service level, there was limited evidence of how the quality of care given to children and young people was being measured and how the information being gathered was used to improve the service.
- The paediatric consultants had monthly meetings which were minuted. The meeting was held to discuss the service and any present issues.
- Any changes from the wider trust were cascaded to ward staff through the matron's weekly meetings and the chief executive's email updates.

Leadership of service

- There was a lack of training, development and supervision for nursing staff. When staff were asked about their professional development all staff agreed there was no protected time or support to develop their roles. Staff shortages made it difficult for staff to arrange training days.
- Management on wards was apparent, staff members knew of the matron and the director of nursing. The paediatric ward manager was newly appointed and had already made changes to practice, such as taking ward level responsibility for training and initiating a CAMHS audit.
- There was evidence of strong leadership and close working relationships between medical and nursing managers on the neonatal unit.
- The staff we spoke to felt disconnected and unsupported at board level. The service did not have regular meetings with the non-executive/executive director with responsibility for their service.

Culture within the service

- Nurses and medical staff on both the paediatric and neonatal ward we visited worked extremely well together. Staff were open and transparent.
- Staff told us they felt confident about approaching senior medical staff when they were on or off duty if they needed to. We observed staff supporting each other to deliver care. Trainees felt supported by their consultants and ward managers.
- Nurses described the culture on the ward as good. They said that they encouraged each other and felt free to express their opinions.
- Staff we spoke to were unsure about the nursing strategy and in many cases despite knowing who the director of nursing was, the nurses we spoke to had never met her.

- The relationship between staff in the children's emergency department and children's assessment unit was strained. We were told that both areas did not communicate with each other and worked in isolation. The ward managers were aware of the difficulties and agreed the situation had developed because of staff shortages on both units. We were assured that plans to rotate staff between the children's ward and children's assessment unit were in place and rotation would commence before the end of 2015 to alleviate the current difficulties and by doing so improve the way the service operates.

Public engagement

- The neonatal unit showed good examples where they had engaged with parents to drive their service to provide better care. We observed a 'neo-mates' meeting, this is a meeting organised for parents "mates" of neonates to discuss their concerns and experiences with one another. The neonatal ward had also set up a face book page to engage with parents, the page was regularly updated and was used as an opportunity to share experiences and advice.
- On the paediatric ward there was not a patient/parent involvement group. Feedback about the service was received via the friends and family survey but participation was low.
- There was no governor with responsibility for representing the service on the governors' board.

Staff engagement

- Senior managers discussed the importance of their service but felt communication and interaction with the trust board was limited.
- Managers felt they worked separately to the other services in the organisation.
- Staff we spoke to on the ward were aware of how to escalate any concerns and felt supported by their managers. They were familiar with the trust whistleblowing policy and how to access it.

Innovation, improvement and sustainability

- Managers at a local level advised that the children's emergency department opening times needed to be longer and this had been recorded on the risk register.
- On the neonatal unit parents were supported with planning how to take care of their baby at home. Staff had developed a discharge board clearly displaying several headings was located in the ward, once all of the headings had been marked off; their baby was ready to be discharged home. Staff told us this initiative was implemented as a result of feedback from parents who wanted clarity and involvement in their child's discharge plan.

End of life care

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

Information about the service

End of life care services at Wirral University Teaching Hospital (WUTH) for the purposes of governance are reported through the medicine division. Patients with end of life care needs at the trust are nursed on general wards.

The trust reported 1,567 deaths in during 2014/2015, which equates to an approximate 3% increase on the 2013/2014 statistics.

The hospital provides a consultant led specialist palliative care (SPC) nurse team, who are not ward based. The SPC team develop treatment plans and symptom control for patients which the general nursing teams then deliver. An important function of the SPC nurse team is the management of complex cases.

The SPC team provide an advisory and supportive service whilst the medical and nursing management of the patient remains the responsibility of the ward teams. The SPC team provide ward support and home visits that are designed to facilitate the transfer of the patient from the curative to the palliative approach for their incurable illness. The trust has a bereavement team that can provide support to relatives following the death of those close to them. There are also well organised links with charitable and voluntary organisations providing hospice care, counselling and bereavement support.

We visited Arrowe Park Hospital as part of our announced inspection on 16 - 18 September 2015. During this inspection we visited inpatient wards including ward 11 (orthopaedic trauma), 16 (older people assessment unit), 23 (care of the elderly), 36 (gastro-entorology) and the acute medical unit (AMU) where end of life care was being provided. In addition we visited the spiritual centre, bereavement office, the discharge team base office, hospital mortuary and the viewing room.

We observed care and spoke with four patients and their relatives, 28 members of staff across all disciplines including bereavement services, mortuary staff, chaplaincy, nursing staff, medical staff, allied health professionals and porters. We also spoke with three specialist palliative care nurses, the clinical lead for palliative care and the palliative care consultant. In addition we followed and observed the work of SPC nurses within the hospital who provided advice and support for patients and their families. We also spoke with two people receiving support from the SPC team and their relatives and we spoke with three relatives of people who were close to the end of their life.

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

End of life care

Summary of findings

There was an insufficient number of general nursing staff who had received appropriate training regarding end of life care. The palliative care consultant staffing levels across the trust were below the recommended guidelines.

The trust performed worse than the England average in the National Care of the Dying Audit, published in May 2014. The trust's policy did not clearly specify in which cases staff were required to complete do not attempt cardio-pulmonary resuscitation (DNACPR) forms or how long after a patients admission they had to complete them.

DNACPR information was not always readily available to staff if a patient re-presented at the hospital following their discharge.

There was a draft three-year vision developed by the trust's end of life care committee. However, we found no evidence that this had as yet, been communicated to SPC and general ward teams. We could not find evidence of any overarching monitoring of the quality of the service across the trust. Complaints were not always responded to appropriately.

Interim guidance and a toolkit had been put in place following the removal of the Liverpool Care Pathway nationally in 2013. Whilst a replacement care plan had recently been agreed not all staff were aware of it and we did not see it being used.

SPC nurses were able to describe safeguarding procedures and provided us with examples of how these would be used. Staff we spoke with were aware of how to report an incident or raise a concern. Appropriate equipment was available to patients at the end of their life; the equipment at the hospital was adequately maintained. Medicines were managed appropriately.

Patients were involved in care planning and decision making. Staff were respectful and treated patients with compassion. Specialist palliative care team members were visible, competent, and knowledgeable. Staff were aware of how to report an incident and raise a concern.

The trust had a dedicated specialist palliative care team who provided good support to patients at the end of life. Care and support was given in a sensitive and compassionate way. Staff worked hard to meet and plan for patient's individual needs and wishes. Staff within the SPC team were very motivated and committed to meeting patients' different needs at the end of life and were actively developing their own systems and projects to help achieve this.

End of life care

Are end of life care services safe?

Requires improvement

There was an insufficient number of general nursing staff who had received appropriate training in palliative/end of life care. The palliative care consultant staffing levels across the trust were below the recommended guidelines.

Do not attempt cardio-pulmonary resuscitation (DNA CPR) information was not always readily available to staff if a patient re-presented at the hospital following their discharge. However, records when available were adequately completed.

Specialist palliative care (SPC) nurses knew how to report incidents and gave examples of things they would report. However, we found no formal mechanisms to share learning from incidents across other teams such as the community discharge team, the bereavement service or nursing teams.

Medicines, including anticipatory medication were prescribed appropriately. Appropriate equipment was available to patients at the end of their life and it was adequately maintained.

SPC nurses were able to describe safeguarding procedures and provided us with examples of how these would be used.

Incidents

- Staff were aware of how to report an incident or a concern and gave examples of the types of things they would report. For example, mortuary staff said they would complete an incident form if they had any concerns regarding either the moving and handling or presentation of a deceased patient or regarding correct identification procedures.
- Staff told us that issues and incidents relating to patients were discussed during weekly multi-disciplinary meetings. However, we found no formal mechanisms to share learning across other teams which supported patients and their families at the end of life, such as the community discharge team, the bereavement service or general ward nursing teams.
- We reviewed records and documentation which confirmed that teams maintained an updated list of incidents and issues relating to patients, as well as completing the trusts online reporting system. For example, we saw records which confirmed that issues relating to delays in issuing death certificates had been reported on the trust wide system. However, alongside this the bereavement service kept their own records relating to the number of incidents where death certificates had been delayed and the detail of each delay.
- When patients were readmitted through the accident and emergency department, information was not always readily available. Prior to our inspection we were told of an incident in April 2015, where staff began to resuscitate a patient, despite having a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) in place. In discussion with staff it was evident that the reason this incident occurred was because the trust's electronic data management system did not immediately identify DNACPR information when the patient was re-admitted through the Accident and Emergency department. We reviewed the trusts electronic patient management system at the time of the inspection and found that DNACPR details were there but they were not immediately accessible to staff. Data received from the trust confirmed that this incident had been raised in April 2015, however we found no evidence of any actions having been taken to minimise the risk of this happening again.
- Medical staff demonstrated an understanding of their individual responsibilities in relation to the duty of candour. This involved medical staff being supported to be open and honest and apologise when things go wrong. Incident reports included a prompt to remind staff to send a duty of candour letter where appropriate.

Cleanliness, infection control and hygiene

- The trust had policies for the prevention and control of infection and hand hygiene. Both were available on the trust's intranet and staff could show us how to access them.
- Staff were observed to be using personal hand sanitising equipment when entering wards to visit patients and personal protective equipment was available for the SPC team if required.

End of life care

- The mortuary was visibly clean, well ventilated and free from odours. A member of staff told us that it was cleaned Monday to Friday, but we could find no documentary evidence to confirm this within the mortuary.
- Mortuary services were licensed by the Human Tissue Authority (HTA). The service had undergone a HTA inspection in February 2014 and HTA certification was visible in the mortuary.

Medicines

- The lead nurse on each of the wards we visited was able to describe the process used in relation to the administration of controlled drugs to people who used the service.
- We reviewed the trust's policy for the management of controlled drugs and found this was current and reflected guidance.
- Anticipatory medication was prescribed appropriately. We reviewed three medication administration record charts across three of the wards we visited and saw appropriate prescribing. Written guidance was available for doctors to prescribe appropriate end of life medicines to manage patients' pain, anxiety and other symptoms.
- Records showed that patients referred to the specialist palliative care team had their medicines reviewed by them. This was done in consultation with other medical staff involved with the patients' care.

Records

- We looked at eight care plans used to assess and record patients' care needs and found that they reflected national guidance. These records were clear, legible and up to date. Records included completed risk assessments for example, falls, nutrition and pressure relief.
- We reviewed five DNACPR forms held in patient records on three different wards. These, when in place, were fully completed. They contained information including who had approved the final decision and who was consulted in the process of a decision being made. However, we observed that DNACPR forms were not filed in patients' notes in such a way that there were easily accessible to staff. We reviewed the trust electronic patient data management system and found four incidences where paper DNACPR forms were completed in individual paper files but this information was not always readily available to staff on the electronic system.
- We were told the trust carried out a monthly audit of do not attempt cardio-pulmonary resuscitation (DNACPR) forms.
- Risk assessment forms completed by the nursing team were complete and easily accessible.
- Recording systems were in place in the mortuary to ensure patients were admitted and kept appropriately. The mortuary records we reviewed, which included body release forms, were accurate, complete, legible and up to date.

Safeguarding

- There were trust wide safeguarding policies and procedures in place, which were accessible via the trust's intranet site.
- Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.
- SPC team members were able to describe safeguarding procedures and provided us with examples of how these would be applied. Staff were able to tell us about safeguarding concerns they had raised previously and said they had always been supported by their line manager in raising concerns.
- Records supplied by the trust indicated that all staff in the specialist palliative care team had completed level 2 safeguarding training for adults and children, against a trust target of 85%. This training was mandatory.

Mandatory training

- The specialist palliative care team provided records of mandatory training completed by the nurses in the team. This training included health and safety, infection control and safeguarding children and vulnerable adults. The records showed seven nurses were up to date with all of their mandatory training.
- End of life care training for registered nurses across the trust consisted of a one day introduction to palliative care course, which was part of the trust's essential training programme and the trust confirmed this was due to be undertaken every three years. Clinical support workers across the trust also had to undertake a half day training course every three years and end of life care was included as part of the trust's induction

programme. However, we found that general ward staff could not confirm when they last undertook specific training in care of the dying. Senior managers confirmed this training had not been kept up to date for nursing staff and clinical support workers but that this was being addressed by the two new end of life facilitators.

Assessing and responding to patient risk

- The SPC team monitored the trust's performance in line with established best practice for patients who required palliative or end of life care.
- Nursing staff on all of the wards we visited could articulate what to do if a patient deteriorated. Ward staff were aware of the escalation processes to seek senior medical and nursing support and were able to define what they would do in an emergency. Ward staff had contact details for the SPC team and confirmed the team responded promptly when needed.
- In the eight patient records we reviewed, we noted that there was evidence of risk assessments being completed appropriately. Risk assessments for venous thromboembolism (VTE), pressure ulcers, nutritional needs, falls and infection control risks for patients receiving palliative/end of life care were conducted by the nursing teams on the wards where patients were being cared for.
- A system was in place to identify patients individual needs, such as those patients at the end of life by use of a discreet symbol on the patient detail 'white boards' visible at the nursing station on each of the wards we visited. Staff showed an understanding of these symbols on the wards we visited.
- Patients on the general wards who had been given a palliative diagnosis had easy access to call bells and we observed their calls were responded to promptly. This was supported by relatives that we spoke to.

Nurse staffing

- Staffing for end of life care was the responsibility of all staff across the wards and not restricted to the SPC team.
- The SPC team consisted of four palliative care clinical nurse specialists whose services were commissioned from another local trust. There were two end of life facilitators who supported staff on wards with training. Staff told us their workload was manageable.
- The team responded to all referrals from clinicians throughout the trust for adult patients who had complex support and/or complex symptom management needs during end of life care. This included support to families of patients referred.
- The specialist palliative care team screened and allocated all new referrals on a daily basis. Current work and new allocations were reviewed every morning by the team and work was allocated based on patient need and urgency.
- The SPC team worked across the trust, as part of a multi-disciplinary team, liaising with all those involved in delivering end of life care including the integrated discharge team.

Medical staffing

- There were two part time palliative care consultants who worked at the hospital, which represented 0.7 whole time equivalent (WTE) posts. This was below the recommended staffing levels outlined by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance, which states there should be a minimum of one WTE consultant per 250 beds. This trust has 855 beds which equates to in excess of three WTE consultants.
- Weekend and out-of-hours on-call advice was provided by consultants employed by the trust who worked across the integrated service covering the hospital, community and hospice settings. Staff could use this facility to access specialist advice and support if a patient deteriorated on any of the wards.

Major incident awareness and training

- The trust had a major incident policy in place but not all ward staff we spoke with were aware of it. Patient needs were prioritised and staff assisted on the wards to keep patients safe.
- Staff we spoke with within both the mortuary and SPC teams were aware of the plans and described the action they would take in the event of a major incident.
- In the event of a major incident, the mortuary had a policy for staff to consult. Mortuary staff described these arrangements. The trust had additional space available in the event of a surge in demand for refrigerated mortuary space, such as following a major incident.

End of life care

Are end of life care services effective?

Requires improvement

Interim guidance and a toolkit had been put in place following the removal of the Liverpool Care Pathway nationally in 2013. Whilst a replacement care plan had recently been agreed by the trust, not all staff were aware of it and we did not see it being used.

The trust performed worse than the England average in seven out of the ten clinical key performance indicators of the National Care of the Dying Audit, published in May 2014, relating to patient outcomes. The audit also indicated that only 42% of patients' had been reviewed in the last 24 hours of life, which was worse that the England average.

Patients had appropriate access to pain relief. However, this was not always administered in a timely manner.

Data received from the trust during our inspection confirmed that only 57% of bereaved relatives received death certificates in the time frames specified within the trust policy.

Specialist palliative/end of life care team members were competent and knowledgeable and there were examples of multidisciplinary team working. The specialist end of life team was valued by ward staff. The team were reported to be accessible, responsive and effective in supporting patients with complex end of life care needs and staff training needs.

The specialist team was available Monday to Friday, 9am to 5pm. Out-of-hours on-call support for general ward staff was provided by consultants employed by the trust who worked across the integrated service covering the hospital, community and hospice settings.

Staff within the specialist team were suitably qualified to perform their roles and had the opportunity to gain experience through extra high level training which was offered to enhance skills.

Evidence based care and treatment

- The specialist palliative care (SPC) team worked in line with best practice and national guidelines such as National Institute for Health and Care Excellence (NICE) quality standard 13 relating to end of life care for adults. Clinical audits included monitoring of NICE compliance and other professional guidelines.
- Staff within the SPC team were highly trained and had a good understanding of existing end of life care guidelines.
- Senior managers we met with could not confirm that the general nursing staff were delivering all of the five priorities for care of the dying. These priorities are defined by the Leadership Alliance for Care of Dying People (NHS England) 'One Chance to get it Right' 2014.
- The trust's end of life care plan had previously been based on the Liverpool Care Pathway (LCP) for the dying patient. Whilst a replacement care plan had recently been agreed by the trust, not all staff were aware of it and we did not see it being used. However, at the time of the inspection and separate from the trust's agreed care plan, the SPC team were in the process of developing a new personalised care plan. The SPC team told us that, following the withdrawal of the LCP, in 2013 an individual care planning toolkit was being introduced. We saw the 'toolkit' in situ on two of the wards we visited. This incorporated the Department of Health end of life care strategy, and aimed to support staff with identifying patients' preferences and wishes earlier in their disease trajectories; in order for improved advance care planning to take place. General ward staff we spoke with were not able to tell us anything about the new way of care planning or about any training they had received regarding improved advanced care planning and we did not see it being used. This meant that we were not assured that the trust's end of life care strategy had been effectively shared amongst staff on the wards following the withdrawal of the LCP

Pain relief

- Staff were able to access clear guidance on the prescription of medications to be given 'as required' for symptoms that may occur at the end of life, such as pain, anxiety, nausea, vomiting and breathlessness. Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to promptly manage any changes in patients' pain or symptoms.

End of life care

- Pain was reviewed for efficacy and changes were made as appropriate to meet the needs of individual patients. We spoke with the relatives of two patients who told us pain relief had been provided in a timely manner.
- Staff confirmed that syringe drivers were accessible if a patient receiving end of life care required subcutaneous medication for pain relief. We were told this service was available seven days a week and during out of hours periods. However prior to our inspection we were made aware of two incidents where patients had required subcutaneous pain relief and there had been a delay in receiving the medication they required. This meant that on occasion patients at the end of their life did not have their pain managed effectively. This was confirmed by patient's relatives we spoke with and by incident data provided by the trust prior to our inspection.

Nutrition and hydration

- The trust participated in the National Care of the Dying Audit, published in May 2014, which found that 43% of patients had undergone a review of their nutritional needs, which was better than the national average of 41%. Data received from the trust prior to inspection confirmed that reviews of patients hydration requirements were above the national average.
- Patients' records showed those identified as being in the last hours or days of life had their nutrition and hydration needs evaluated and appropriate actions followed. These records documented subsequent discussions with relatives. Three relatives of patients we spoke with confirmed ward staff had clearly explained nutrition and hydration.
- All of the patients we spoke with were happy with the food and drink provided by the hospital. They had access to drinks and these were within their reach. We observed nutritional assessments were completed and nursing records, such as nutrition and fluid charts were completed accurately. We saw that menus catered for cultural preferences.

Patient outcomes

- Patients receiving palliative and end of life care were not always managed effectively. Patients received effective support from a multidisciplinary team, which included specialist palliative care nurses and consultants. However records received from the trust both prior and during inspection detailed several occasions when patients at the end of their life, and bereaved families, had not been managed effectively. For example one patient's family had to wait six days for a death certificate to be signed, this was corroborated during conversations we had with members of the bereavement service. Data received from the trust during our inspection confirmed that only 57% of bereaved relatives received death certificates in the time frames specified within the trust policy. Relatives we spoke with prior to our inspection, told us that this had caused them added stress and had contributed to their existing distress at the loss of a family member.
- The results of the National Care of the Dying Audit (NCDA), published in May 2014, showed that 42% of patients had a review in the last 24 hours of life, which was worse than the England average of 82%. Only 25% of patients' and their nominated relative or friend had undergone an assessment of their spiritual needs, which was worse than the England average of 37%. However, the NCDA also reported 96% of patients had been recognised as dying and at the end of their lives, which was much better than the England average of 61%.
- Patients received care in line with national guidelines. Clinical audits included monitoring of NICE and other professional guidelines.

Competent staff

- Appraisals in relation to the specialist palliative/end of life care team were being undertaken and staff spoke positively about the process. The trust provided appraisal data for May 2015 which showed that all staff had undergone a yearly appraisal.
- The SPC team confirmed they received monthly clinical supervision to support them in their role and they had received an appraisal in the last 12 months.
- Records showed that the SPC team had regular one to one meetings. Staff told us they received clinical supervision every six weeks and were meeting their mandatory training requirements. This was supported by information we had received from the trust.

Multi-disciplinary working

- MDT meetings were held on the wards to discuss and manage patient risks and concerns. Patients at the end of life were included in this discussion so all disciplines could contribute to effective and consistent care for these patients.
- Staff discussed patients with a palliative/end of life prognosis and SPC team involvement, at the

multidisciplinary meeting. This helped to ensure that information regarding patients at the end of their life was effectively shared among the different nursing/ medical teams working with them.
- The SPC team lead told us that the team tried to attend as many multidisciplinary team meetings as possible. This was undertaken to share the work of the team and help identify and coordinate care for an individual approaching the end of life or requiring supportive care. Records confirmed that members of the team regularly attended multidisciplinary team meetings.
- The SPC team said they supported other health professionals to recognise and consider when patients may be approaching the need for palliative or end of life care.
- The SPC team had established links with community palliative care services and other community services, such as district nurses. Staff said this promoted shared learning and expertise and enabled complex patients who switched between services to have consistent care.
- Records confirmed that staff met as a clinical review group weekly, during which SPC staff had the opportunity to discuss relevant issues.

Seven-day services

- The hospital consultant and the SPC team offered a five day Monday-Friday 8am -6pm service across the trust's hospital sites. Out of hours there was a hospice hotline covered by consultants on a 1:5 rota 24 hours a day, seven days a week. In addition, the on-call consultant also had hospice and community duties.
- All ward staff we spoke with said the SPC team responded promptly to referrals, with many patients being seen the same day or within 24 hours, dependant on prognosis.
- Staff reported there were no issues in accessing diagnostic services which were available 24 hours a day, seven days a week.

Access to information

- We saw examples of where patients moved between services and teams, for example, from the hospital to their own home. We reviewed records which confirmed information to support their care was available to staff in a timely way. However, prior to our inspection during listening events we held for the community, we were made aware of two occasions where the process had failed. This information was confirmed by incidents which we obtained from the trust prior to our inspection. While this confirmed that the trust were aware of the particular incidents, we could find no evidence that the issues had been examined and strategies had been put in place to minimise the risk of the similar incidents happening in the future. During discussions with the trust's integrated discharge team, it was clear that they were not aware of at least two incidents where the rapid discharge process had failed. We were therefore unable to confirm that staff had appropriate access to information designed to improve patient experience when they moved between services.
- Nurses and doctors on all the wards we visited told us they felt they had sufficient access to information in order to support clinical decision making.
- We identified issues with access to information regarding patient's wishes in the last days or hours of life. We saw that staff in the SPC team had reported their concerns around access to electronic data concerning patient's wishes, through the trust's internal reporting processes.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place. The policy included advanced decisions, lasting power of attorney, mental capacity guidance and the use of independent mental capacity advocates where necessary.
- Staff received mandatory training in safeguarding children and vulnerable adults, which included aspects of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DOLS).
- Staff within the SPC team understood the legal requirements of the MCA. Records we received from the trust prior to our inspection confirmed high levels of staff training.
- In all cases, do not attempt cardio-pulmonary resuscitation (DNACPR) forms were signed by an appropriate senior clinician. Patients' views relating to resuscitation were clearly recorded in their notes and on the form. However, it was not routinely noted or monitored whether the patients' capacity to make and communicate decisions had been assessed. It was not clearly noted when the DNACPR should be reviewed once in place. General nursing staff we spoke with could not tell us how often DNACPR forms should be reviewed.

End of life care

- Both specialist nurses and general nursing staff were able to describe their duties and responsibilities under MCA. SPC nurses and general ward staff were able to define procedures to us and provided us with examples of how these would be applied.

Are end of life care services caring?

Good

Palliative and end of life services were delivered by highly trained, caring and compassionate specialist staff. Specialist palliative care team members interacted with patients in a respectful way. Care was planned in a way that took into account the wishes of the patients.

The patients and relatives we spoke to told us they felt involved with care and were treated with dignity and respect. Staff provided a caring service and people told us that they generally felt happy with the care and support both they and their families received. Interactions between staff and patients demonstrated a kind and compassionate approach. Staff within the specialist team were highly sensitive to the needs of patients who were seriously ill and recognised the impact this had on the individual patient and those close to them.

Patients received compassionate care and their privacy and dignity were generally maintained. A minority of people felt their experience could have been better with improved communication between medical and nursing staff and relatives. Patients felt staff on the wards were, "always really busy" and that more staff were needed. Despite that, staff came quickly when they were called and were "respectful and kind" when they were delivering care.

Compassionate care

- Patients were treated with compassion and empathy. We observed ward staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner.
- The patients and relatives we spoke with were mostly complementary about staff attitude and engagement. We observed a patient that had difficulty with speech was listened to patiently and staff responded to their query appropriately. Comments received from patients demonstrated that staff cared about meeting patients' individual needs. For example one person, whose relative was receiving care and support commented; "All the staff are really lovely; they have all been so kind."
- Patients said the staff had been nice and kind and they had no complaints about care they had received. We observed patients and relatives were treated with compassion.
- Ward staff told us where possible, end of life patients were accommodated in side rooms to increase dignity and privacy for them and those visiting.
- Ward staff told us hospital porters were respectful when caring for deceased patients before they were transferred to the mortuary.
- Porters told us staff in clinical areas and mortuary staff handled patient's bodies in a respectful way. This was confirmed by relative's feedback via thank you cards, which we reviewed.
- SPC staff told us it was a privilege to provide care and support to people at the end of their life and saw the role of the specialist nursing team as vocational.

Understanding and involvement of patients and those close to them

- Patients and their relatives described how staff had worked to establish a good rapport with patients, their relatives and close friends. All of the people we spoke with were highly complementary regarding the way staff had cared for and supported them.
- We witnessed staff awareness of people's beliefs and observed how they changed their approach accordingly by communicating with patients and relatives using terminology and language relevant to the situation.
- Staff provided patients with information on how to contact the palliative care team. People we spoke with told us that the specialist team were able to advise them on where to obtain additional support and information. Patients said they felt involved in their treatment and that staff explained each of the stages and optional treatments available.
- On the wards we saw examples where families were encouraged to participate in aspects of care of their loved one, for example, mouth care.
- A minority of people felt their experience could have been better with improved communication between medical and nursing staff and relatives. Patients felt staff

on the wards were, "always really busy" and that more staff were needed. Despite that, staff came quickly when they were called and were "respectful and kind" when they were delivering care.

Emotional support

- Although specific information leaflets or booklets were available on the wards we visited, people told us that staff had not always informed them about local services such as counselling services and services providing assistance with anxiety and depression. One person commented; "It depends who is on really, some of the staff are lovely and really take time to see how I am doing. Others just seem to rush about and don't really tell you anything. It makes it difficult to know who to ask if I have any questions."
- There was a quiet space on most wards where sensitive conversations could be held and staff confirmed these were used to talk with relatives and patients.
- There was a bereavement office, which issued death certificates and provided relatives with information on support services available to them, and what to do following a death.
- Chaplaincy services were available on request. A chaplaincy team member told us that they were able to offer spiritual support to patients of all or no faiths as they had developed close links with local churches and members of various congregations. Prior to our inspection we had received positive feedback from families regarding the bereavement service provided.
- Patients' records showed discussions of sensitive conversations that had been held with patients and relatives.

Are end of life care services responsive?

Requires improvement

Complaints were not always responded to promptly and no evidence was found to confirm actions had been taken in response to some complaints and comments received by the trust about the service.

Data received from the trust during our inspection confirmed that some relatives had waited over five working days to access a death certificate.

There was a rapid discharge system in place to discharge patients approaching the end of life to their preferred place of care. However, prior to inspection we received information from two families, which suggested that on at least two occasions over the previous six months the 'rapid discharge' system had failed. Staff in the integrated discharge team, were not aware of these incidents and there was no evidence of shared learning from these incidents.

Patients had adequate access to the specialist palliative care (SPC) team and staff were able to identify those who needed the service. There was specialist support available 24 hours day, via an on call system. Specialist palliative care team members were visible and staff knew how to contact them. End of life care services were responsive to the needs of the local population.

The trust had a new draft strategic plan, which aimed to improve and connect services to prevent patients having their care compromised with admissions and readmissions to hospital. The SPC team had a flexible referral process. Ward staff told us the SPC team responded promptly to referrals, usually within 24 hours. We found people's diverse needs were met and that there were appropriate provisions of care for patients and their families in line with their personal or religious wishes.

Service planning and delivery to meet the needs of local people

- Specialist palliative care (SPC) staff had a good understanding of the needs of the local population. Staff worked as part of multidisciplinary teams and routinely engaged with local hospices, the trust discharge team, adult social care providers and other professionals involved in the care of patients.
- General nursing staff on the wards told us they were confident patients could access end of life care services when needed. The SPC team routinely engaged with nursing staff, local hospices and adult social care providers so patients could be referred promptly and to provide advice, where necessary.
- There was open access for relatives to visit patients who were at the end of life.

Meeting people's individual needs

- Staff within the SPC team were responsive to patients' needs and provided an appropriate level of care and

support, based on prognosis, and the individual complex needs of each patient. Staff communicated on a daily basis with ward nurses and we observed staff regularly checking patients' electronic records.
- Patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We saw that risk assessments were completed by staff and updated as the patient's condition changed.
- We saw records which confirmed that where a patient was identified as having issues relating to learning disabilities, dementia or cognitive impairment staff could contact specialist nurses within the trust for advice and support.
- The chaplaincy service responded to the spiritual needs of end of life patients and their families. This included providing last rites services. The chaplaincy service had a multi-faith prayer room and provided multi-faith services and individual spiritual support and guidance as required.
- Patients who used the service were asked about their spiritual, ethnic and cultural needs as well as their medical and nursing needs. General ward staff took the needs and wishes of the patients into account when caring for them.
- There was a policy in place for the rapid release of a deceased patient from the mortuary. Medical and mortuary staff demonstrated an understanding of the processes to follow. This enabled the cultural wishes of families to be respected.
- There was printed information available for patients and their relatives, including leaflets on what they needed to do after their relative died, as well as the emotional support available. However we noted that all of this information was only readily available in English.
- Staff could access an interpreter for patients whose first language was not English if needed

Access and flow

- The SPC team, which worked across two hospitals managed by the trust, received 783 referrals in 2014/15. These included patients, continuing patients and re-referrals to the service. The team predominantly saw patients as inpatients but also ran an outpatient service and provided telephone advice when needed. The SPC team had a flexible referral process. Ward staff told us the SPC team responded promptly to referrals, usually on the same day.
- There was a clear standard set for allocating patients to the specialist palliative care team and who could refer a patient and how they should do this. End of life care was delivered where required by ward staff throughout the hospital. The SPC team was accessible during normal working hours each day. Outside of those hours advice was available to staff via telephone. This could be accessed by ward staff to gain specialist support and advice regarding complex symptom management.
- Referrals to the SPC team were made by ward staff using the trusts IT system or by telephone. The team met daily Monday to Friday to review current work and allocate new referrals, which were prioritised and allocated based on urgency and need.
- The SPC team were part of a multi-disciplinary team responsible for the arrangements for rapid discharge to ensure patients at end of life died at their preferred place. However, prior to inspection we received information from two families, which suggested that on at least two occasions over the previous six months the 'rapid discharge' system had failed. This was confirmed by data we received from the trust, which showed that both incidents had been recorded using the trust's internal incident reporting systems. We discussed both incidents with staff in the integrated discharge team, who were not aware of these incidents. This meant that communication was not always effective between teams and that there was no shared learning from these incidents.
- Ward staff said delayed discharges of days or weeks impacted on end of life patients. Staff said this was due to the time taken by the local authority to arrange the appropriate care packages for patients.
- Doctors and nurses told us they had access to diagnostics and test results promptly. Records we reviewed confirmed this.

Learning from complaints and concerns

- Complaints were not always handled in line with the trust policy. Records we reviewed confirmed that all complaints should be recorded on a centralised trust-wide system. The clinical leads would then investigate formal complaints relating to specific teams. However, during our inspection we were made aware of three separate incidents which had resulted in complaints to the trust. All of these incidents related to the length of time it had taken for relatives to access death certificates. While all of these incidents had been

recorded at a local level by either the bereavement service or the SPC team, we could find no evidence of any formal investigation being undertaken, nor could we identify any actions that had been taken to address the issues raised by the complainants.

- Data received from the trust during our inspection, confirmed that some relatives had waited over five working days to access a death certificate. The trust's own internal protocol stated that death certificates were to be completed by the next working day in all cases where no input was required from the coroner/coroner's office. The trust protocol also stated that the production of death certificates should take priority over all other commitments, including ward rounds and clinics. However, we found no evidence to confirm that this protocol was reviewed as part of quality management audits to ensure its implementation across the trust. This meant that the trust had no overview of the effectiveness of this protocol, its level of implementation or the impact of delays in death certification on family members.

Are end of life care services well-led?

Inadequate

There was a draft three-year vision developed by the trust's end of life care committee. However, we found no evidence that this had as yet, been communicated to specialist palliative care (SPC) and general ward teams.

We could not find evidence of any overarching monitoring of the quality of the service across the trust and some risks relating to end of life services were not recorded on the risk register. Whilst we did see evidence that the individual teams working with patients and their families had raised incidents using the trust internal system, we saw no evidence of any actions being taken by the trust in response them.

The reports from staff working across services for those at the end of their life as a whole, suggested that end of life services were seen as addition to the main trust focal point of health. As a result, they did not always feel as valued as other colleagues.

The SPC team were aware of issues relating to their specialties and had developed appropriate strategies to ensure incidents were recorded and fed into the wider trust. Staff within the specialist team worked well across the trust.

There were systems and processes in place to ensure staff were trained, supported and appraised and were able to give feedback to the SPC team leader.

Vision and strategy for this service

- We spoke with 28 members of staff as part of this inspection. None of them could tell us about the trusts vision for palliative care or end of life services (a framework for care and support for patients and staff). None of the staff we spoke with could give us examples of how the existing service strategy was being used to deliver trust services.
- General ward staff had limited awareness about the trusts audit strategies. For example, no one within bereavement services or the specialist palliative/end of life care team was able to tell us about the audit schedule of key processes, or if one was in place.
- Bereavement services across the trust service needed to raise its profile and required strong senior clinical management support; to assist in developing a clear overriding strategy for the palliative or end of life services.

Governance, risk management and quality measurement

- We saw limited evidence of an effective, overarching performance quality system for specialist palliative or end of life care. Records we reviewed confirmed that the various aspects of the service were monitoring their own performance with monthly updates. These updates consisted of reviewing patient feedback, waiting times from referral to first appointment, patients care files, and access to death certification. However, whilst we did see evidence that the teams were raising incidents using the trust internal system, we saw no evidence of any actions being taken by the trust in response to incidents being highlighted by the staff.
- In discussion with the various teams across the trust, no one could give us a clear overview of how the quality of service delivery was reviewed at trust level.
- We observed many excellent examples of caring, and high quality care and support offered to patients and

their families. However, we felt that the trust could work to develop a culture of more open conversations around sharing the expertise of the specialist palliative care team and encourage closer working across bereavement services, as part of the patient's journey.

- Minutes from the palliative and end of life care meeting in June 2015 highlighted that it was difficult to review incidents specifically relating to palliative or end of life patients but a flag had been added to the electronic system so staff could identify patients approaching the end of life or receiving palliative care when reporting an incident. There was no evidence to suggest how staff had been or would be alerted to this change in approach when recording incidents.
- The July 2015 risk register for end of life had one risk recorded which related to staffing. However, there were no risks identified relating to issues such as a lack of end of life training for ward based nurses or the withdrawal of Liverpool Care Pathway (LCP) and subsequent lack of tried and tested care plans for patients approaching the end of life.
- During our inspection we were told that audit results for do not attempt cardio-pulmonary resuscitation (DNACPR) forms are discussed at the trust wide clinical governance team meeting and then escalated to the clinical governance group.

Leadership of this service

- The service had an executive and non-executive lead for end of life care, as well as a clinical lead and a governor. The end of life facilitators were managed through the nurse practice development lead who was in turn led by the Director of Nursing. The specialist palliative care (SPC) nurses were managed by their parent organisation.
- The SPC team demonstrated effective leadership and the leader understood the challenges to provide good quality palliative and end of life care services across the trust.
- The SPC nurses were described by colleagues as knowledgeable, supportive and passionate about end of life practice. Several staff members of the team said the team was brilliant to work in because of their good communication and excellent peer support.
- Staff throughout the trust said the SPC team were visible, approachable and accessible. Ward staff we spoke with valued the expertise and responsiveness of the SPC team and said patient outcomes and clinical practice improved as a result of the support they provided.

Culture within this service

- Staff we spoke with across the trust were positive about the SPC team and bereavement services as a whole. Staff said they felt that they were responsive and supportive to ward nursing staff managing patients at the end of their lives.
- Staff reported that working within the SPC team was an extremely positive experience. All of the staff members we spoke with told us that their major source of support was the other members of the team and the team manager. Ward staff told us that they felt the specialist team was a major source of support.
- Staff within the SPC team were highly motivated and positive about their work. Staff told us they received support from their immediate line manager.

Public engagement

- The bereavement officer gave out information packs to families when they came in to pick up death certificates.
- On the wards we visited where an end of life toolkit was present, we saw information for relatives, relating to financial advice and support/bereavement counselling services and details relating to accessing occupational therapy and social work support.
- The SPC team was evaluating ways to more effectively collate the views of patients and bereaved relatives.

Staff engagement

- Staff reported that despite completing the NHS staff survey, they did not know if any actions had been taken or if there were actions to be taken as a result of this.
- We found that the annual appraisal system worked well and that staff were up to date or had received dates for their appraisals. Staff reported that this was useful and gave an opportunity to address any problems.
- Staff in the SPC team had an annual appraisal which they told us worked well and as a small team they had the opportunity to raise and discuss any problems with each other.

Outpatients and diagnostic imaging

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

Information about the service

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

The outpatients and diagnostic imaging departments at Arrowe park Hospital are located on the ground level. In the twelve months prior to our inspection 430,391 outpatient appointments were offered across the trust with 288,191 appointments offered at Arrowe Park Hospital. There had been an increase of 12% in activity over the past two years.

Arrowe Park Hospital offers a combination of consultant and nurse-led clinics for a full range of specialities these included: trauma and orthopaedics, respiratory, colorectal, podiatry, endocrine, cardiovascular, ear nose and throat (ENT), diabetic, fracture clinic, ophthalmology, rheumatology, phlebotomy and therapy services.

Arrowe Park Hospital offers a comprehensive range of diagnostic and interventional radiography services to patients including: general x-ray, computerised tomography (CT) scans, magnetic resonance imaging (MRI) and ultrasound scans. The laboratory services provided a range of diagnostic testing to enhance and support patient diagnosis and treatment.

We visited Arrowe Park Hospital between 16 and 18 September 2015 and inspected a number of outpatient and diagnostic services including: ear, nose and throat (ENT), fracture clinic, cardiovascular, ophthalmology, rheumatology, urology, pathology, haematology, radiology and diagnostic imaging services. We spoke with 12 patients and 101 staff including nursing, medical, allied health professionals, clinical support workers, administration staff and managers. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and looked at nine individual care records.

Outpatients and diagnostic imaging

Summary of findings

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

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

The radiology department had equipment that exceeded the ten year life span recommended although there was evidence of regular quality assurance and maintenance of the equipment. Equipment failure had resulted in patients experiencing longer waiting times in clinic, or having to return to the hospital due to rescheduled appointments.

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

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

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

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

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

We saw that teams worked well locally but some staff were not formally made aware of key issues following complaints, incidents and audits.

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

There were appropriate protocols for safeguarding adults and children and staff were aware of the requirements of their role and responsibilities in relation to safeguarding.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

There were high levels of staff vacancies across outpatients and diagnostic departments across the whole trust and a high level of sickness within the nursing profession.

There was a clear process for reporting and investigating incidents. Although staff were aware of the process, we found there had been delays in reporting incidents. There were also inconsistencies in learning from incidents was shared at team level.

Medication was stored safely in the general outpatients and radiology departments; however medication was left unattended in ophthalmology consultation rooms.

The trust had paper based medical records that were legible, updated and readily available during clinic consultations. In general, outpatients records were not stored in a way to protect patient confidentiality.

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

Some equipment in radiology had exceeded the recommended ten year life span although there was evidence of regular quality assurance and maintenance of the equipment.

Staff were aware of their role in relation to safeguarding. A reporting process was in place and staff knew how to escalate concerns. Safeguarding and mandatory training was well attended across the whole of the trust for the outpatients, and diagnostic imaging services.

Incidents

- There were no never events reported relating to outpatients and diagnostic imaging services in the 12 months prior to our inspection. However, in the week following the announced inspection, one never event occurred in an ophthalmology clinic. The incident was appropriately reported internally and to external bodies. Investigations into the incident were ongoing at the time of this report. Never events are very serious, wholly preventable, patient safety incidents that should not occur if the relevant preventative measures have been put in place. However, during our inspection, one never event occurred in an ophthalmology clinic. The incident was appropriately reported internally and to external bodies. Investigations into the incident were ongoing at the time of this report.
- There were three serious incidents requiring investigation reported between May 2014 and June 2015. Two of these incidents were in the ophthalmology department. Both incidents were investigated using a route cause analysis (RCA) approach. High priority actions had been identified and implemented in both cases and there was evidence that duty of candour had taken place. However, no process for sharing lessons learnt was recorded on one of the RCAs and there were no actions identified on the action plan even though changes had been made. There had been deterioration in both patients' condition but the RCA did not identify if the delays contributed to the deterioration. There was a delay from the date of the incident to reporting the incident in both instances of five and thirteen days respectively without any rationale for the delay in reporting being identified on the RCA. The third incident related to an incorrectly filed computerised tomography (CT) scan in radiology which was still under investigation at the time of the inspection.
- Specific information for Arrowe Park was not available however; data from across the trust showed there were 38 radiation errors and near misses recorded between 6 April 2015 and 3 September 2015. A near miss is an unplanned event that did not result in injury, illness or damage but had the potential to do so. The trust uses a pause and check process which aims to ensure that the right person gets the right x-ray on the right part of the body. The recording of these near misses suggests that the pause and check process was being used and working.
- We spoke to 101 staff as part of the inspection and 100 of them knew how to report incidents. We saw evidence that incidents were reported and staff were able to demonstrate how they would report an incident and alert a manager when it was submitted. However, we were informed by staff that feedback and learning from investigations of reported incidents was rare.

- In the biochemistry laboratory we saw evidence that learning from incidents was shared at team meetings but this was not consistent across the outpatients and diagnostic imaging departments.
- A duty of candour policy was in place which detailed how patients should be communicated with following a reportable patient safety incident. Many staff did not recognise the term but could describe the principle.

Cleanliness, infection control and hygiene

- All of the areas we visited were visibly clean.
- Policies and procedures for the prevention and control of infection were in place. Staff understood them and could describe their role in managing and preventing the spread of infection.
- Staff complied with the trust's policies and guidance on the use of personal protective equipment and adhered to "bare below the elbow" guidelines. Hand gel was readily available in all the clinical areas and we observed staff using it.
- Hand hygiene audits were on display in ophthalmology, general outpatients and fracture clinic which identified good compliance with hand washing however, the one in ophthalmology was dated January 2014. Staff were able to describe the process of weekly hand hygiene audits and could demonstrate how results were sent electronically to the infection control team.
- Patient-led assessments of the care environment (PLACE) audits for 2013 and 2014 scored higher than the national average for cleanliness across the trust, specific data for Arrowe Park was not available.
- There were additional cleaning services available that staff could call on if required during the day. However, during our visit we observed rubbish such as cans and food left in some patient waiting areas.
- We looked at cleaning schedules in diagnostic imaging rooms but these were not always completed.
- We saw some evidence of best practice in general outpatients where 'I am clean' stickers were used to inform colleagues at a glance that equipment had been cleaned. However, this was not consistent across general outpatients and we were not assured that all equipment was cleaned as frequently as was required. Stickers were not present on two out of five electronic blood pressure monitoring machines in general outpatients and we did not observe any stickers on equipment in ophthalmology.
- Infection control training was attended by staff as part of their mandatory training. Data provided by the trust identified that 97.8% of staff across all outpatients and diagnostics had completed the training, which was higher than the trust target of 95% but the information was not disaggregated to show the figures specifically for Arrowe Park staff.

Environment and equipment

- Following a review of radiology equipment across the trust as a whole, 66% of equipment was identified as being older than the lifespan recommended by the Royal College of Radiologists. The recommended lifespan for general imaging equipment is ten years. Evidence was provided of regular quality assurance and maintenance of diagnostic imaging equipment.
- Staff raised concerns regarding the age, reliability, and speed of some of the diagnostic equipment. Equipment failure had resulted in patients experiencing longer waiting times in clinic, or rescheduled appointments. Staff told us this led to additional pressures on staff to absorb the impact of equipment failure. As part of the inspection, we saw evidence that computerised tomography (CT) scanner number one had broken down on four occasions between 24 August 2015 and 9 September 2015.
- Data provided by the trust showed that there were 133 altered appointments in diagnostic imaging due to equipment failure or equipment being unavailable between September 2014 and August 2015. We reviewed the risk register and as at July 2015 did not see that the age of equipment for radiology had been recorded as a risk. However, we saw evidence that an equipment review had been submitted to the trust board detailing options to ensure continued provision of a comprehensive radiology service.
- Maintenance contracts were in place to ensure that specialist equipment in the outpatient and imaging departments was serviced regularly and faults were repaired.
- Portable appliance testing (PAT) was inconsistent in outpatients departments across the hospital. In the ophthalmology department we saw numerous pieces of equipment that had no PAT test stickers in situ. In the general outpatients department we observed five

electronic blood pressure monitoring machines, and one suction machine with an expired date on the PAT sticker which would indicate the equipment had not been tested by the due date.
- Clear signage and safety warning lights were in place in the x-ray department to warn people about potential radiation exposure.
- Radiology staff were seen wearing dosimeters (a device that monitors ionising radiation levels) and we saw documentary evidence that occupational exposure to radiation was monitored.
- The hospital had three CT scanners and two magnetic resonance imaging (MRI) scanners. Local rules were observed in the staff room and signed by staff that used the equipment
- Each x-ray room had a folder where staff recorded faults with equipment and medical physics staff recorded completed quality assurance tests.

Medicines

- In the ophthalmology clinic on two occasions we observed eye drops for dilating pupils for examination left on trolleys in unattended open consultation rooms. The manager told us there were plans in place to have locked cupboards in the consultation rooms in the future.
- Medication was stored in locked cupboards when clinics were not in operation.
- We observed two drug fridges in general outpatients. Temperature records were complete and contained minimum and maximum temperatures to alert staff when they were not within the required range. A pharmacy support worker checked and rotated the drugs once a week. We checked four sets of drugs from each fridge and all were found to be in date. Contrast agents were observed in locked cabinets, in date, and stored correctly in the radiology department.
- Controlled drugs, such as certain eye drops were occasionally used in ophthalmology and we observed that they were stored and handled in adherence with the controlled drugs policy.
- Non-medical prescribers (NMPs) in outpatients had a lockable cupboard for prescription pads and during clinic they were kept on their person. Two NMP staff we spoke with were not aware of any audits in place to monitor their prescribing activity.

Records

- The outpatient department used a combination of paper medical records and an electronic system where diagnostic imaging, pathology and microbiology results were stored.
- We looked at eight patient records in outpatients. We saw evidence in the records that consent had been gained, records were legible and updated.
- An audit of case note availability in 2014 showed that medical records were available in 99% of consultations across the whole trust in outpatients. There were few occasions when records were not available for an appointment. In such cases, staff prepared a temporary file for the patient that included correspondence and diagnostic test results so that their appointment could go ahead. This meant that the patient did not have to reschedule their appointment and the temporary file was merged with the main file once it was located.
- Patients records were not always handled with due regard to privacy and confidentiality. We observed in general outpatients reception that patient records were placed on the front desk facing the public. When the public approached the reception they would be able to read the patient information sticker on the front of the records.

Safeguarding

- Trust wide policies and procedures were available on the intranet and staff were able to demonstrate how to access them. Staff were aware of their roles and responsibilities in relation to safeguarding and could describe what types of concerns they would report and how they would raise matters of concern appropriately.
- Training statistics provided by the trust for staff across the whole of outpatients and diagnostics identified 96.5% of staff had completed level 2 safeguarding children and adults training and 97.2% of staff had completed level 1, which was above the trust's target of 95%. Specific training data for Arrowe Park Hospital alone was not available.
- In radiology we found that the one member of staff that was required to complete level 3 safeguarding for children had not completed it as at August 2015.

Mandatory training

- Mandatory training was available via on-line courses as well as face-to-face training.
- Mandatory training was delivered on a rolling 18 month programme (Block B) covering areas such as infection

control and medicines management and a 3 year rolling programme (Block A) incorporating moving and handling, risk management and fire safety. At the time of our inspection training statistics for outpatient, diagnostic, and imaging staff across the whole trust showed 95.7% were compliant with Block B and 97.8% with Block A, which was above the trust target of 95%.
- Managers received reports when staff were due to attend mandatory training and this was scheduled into staff rotas.

Assessing and responding to patient risk

- Resuscitation trolleys in outpatients and diagnostic imaging were visibly clean, drug boxes were observed to be in date and checklists completed. The resuscitation trolley in the cardiovascular clinic had recently won 'best trolley in the hospital'. However, in ophthalmology clinic we were told there were times when equipment was missing during the checks and had to be replaced although we did not see incidents of this nature reported.
- Staff demonstrated clinical justification for x-ray examinations and this documented electronically in patient records.
- Safety procedures were in place in radiology and we observed checklists being used to identify if patients were suitable for exposure to radiation. Staff obtained the name, address and date of birth of patients on arrival which related to the 'know your patient' initiative as well as being a requirement of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)(2000).
- Staff were observed taking action when a patient in the cardiovascular clinic felt unwell by supporting the patient to sit and rest.
- In the general outpatients waiting area we observed a water spillage and staff immediately cleaned the spillage and informed people that were passing of the slip hazard.
- Reception staff in general outpatients knew the process for summoning assistance should they see a patient giving them cause for concern or if a medical emergency occurred.

Nursing staffing

- Across the trust there had been vacancies in outpatients for clinical support workers (CSWs) since March 2015 and three vacancies remained at the time of our inspection. However, recruitment was in progress. There were no vacancies for nurses since June 2015 when a reduction to the establishment had been implemented.
- Nursing staff and CSWs in outpatients worked across both Clatterbridge Hospital and Arrowe Park Hospital sites to cover as required. Where staff were unavailable, clinics ran with less staff on duty. On day three of our inspection, general outpatients cover was reduced by eight hours for a clinical support worker who was absent. The department were able to obtain cover for four hours by using bank staff but this left a four hour shortage for the day.
- Where a nurse was unavailable the shifts were sometimes covered by a clinical support worker. Nursing staff informed us that limited availability of nurses during shifts had placed them under additional pressure.
- Sickness absence figures for nursing in outpatients and diagnostics was only available across the trust and not for Arrowe Park Hospital specifically. The trust had a target of 4% staff sickness. However, in the outpatient department the sickness rate for nursing staff was 12.9% in August 2015 and had been consistently high since March 2015, peaking at 16.7% in May 2015. There had been a 29.9% turnover rate across the trust from March 2015 to August 2015 with 5 whole time equivalent (WTE) nurses leaving their position.

Medical staffing

- Medical staff arranged outpatient clinics directly with the outpatient department to meet the needs of their specialty.
- The radiology department was staffed by consultant radiologists 8am-7pm each day and there was a routine presence for six hours on a Saturday and Sunday accessed by a bleep system.

Allied Health professionals

- Information from the trust indicated a vacancy rate of 57.4 whole time equivalent (WTE) across all staffing in the diagnostics and imaging services as of August 2015. This equated to an 8.5% vacancy rate however, recruitment was ongoing. The vacancy rate for diagnostic radiographers in x-ray specifically was 4.2 WTE which equated to a 9.9% vacancy rate.

Outpatients and diagnostic imaging

- A lack of sonographers was highlighted on the trust's risk register however, locums had been employed to reduce waiting lists and those we spoke to had received a comprehensive trust induction and had access to the IT system.
- The radiology department had two paediatric radiologists but at the time of our inspection one was on sick leave and one was due to leave the trust.

Major incident awareness and training

- The trust had a major incident policy in place but not all staff we spoke with were aware of it. Staff were used flexibly across both Clatterbridge Hospital and Arrowe Park when there were staffing issues.
- Staff in the fracture clinic gave us an example how the policy had been used during an electrical failure at the hospital. Patient needs were prioritised and staff assisted on the wards to keep patients safe.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

Staff worked together in a multi-disciplinary environment to meet patients' needs. In some of the outpatient clinics, medical staff were supported by specialist nurses. Staff were competent to perform their roles but development opportunities were limited due to financial constraint.

Information relating to a patient's health and treatment was available from relevant sources before a clinic appointment. After the appointment, the information was shared with the patient's GP and relevant professionals to assure continuity of care for the patient. The radiology and diagnostic service ran seven days a week at the time of our inspection.

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- NICE guidance such as the criteria for performing a computerised tomography (CT) head scans in radiology was in place in the viewing rooms in radiology.
- Audits of compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) indicated that the last published audits were dated 2012, and 2013. However, the trust provided evidence that audits were taking place at the time of the inspection.
- The pathology service had received the clinical pathology accreditation

Pain relief

- Entonox pain relieving gas was administered in fracture clinic when patients needed it. We observed instructions were available to guide staff and they were able to locate the policy on the trust intranet. Entonox was to be administered under the direction of a medical professional and this was clarified in the trusts policy for acute pain management in emergency medicine. However, the policy on the intranet had a review date of May 2014. We did not observe any patients receiving pain relief during our inspection.
- We were told that anaesthetists provided pain relief for interventional radiology procedures although we did not observe this during our inspection as there were no patients requiring this treatment at the time of the inspection.

Patient outcomes

- Discrepancy meetings were held in radiology. The purpose of the meetings was to facilitate collective learning from radiology discrepancies and errors and thereby improve patient outcomes and safety.
- We saw evidence that image review processes in ultrasound were audited and actions identified for implementation.
- The trust did not participate in the imaging services accreditation scheme.

Competent staff

- Staff identified their learning needs through the trusts appraisal process and 93% of staff in outpatients and diagnostic imaging across the whole trust had completed an appraisal within the previous twelve

months of our inspection. This was higher than the trust target of 88%. However, junior staff in ophthalmology told us there was a lack of opportunities for them to develop and progress in their current role. Staff in radiology told us that no additional training was available to develop staff over and above the mandatory training and this was confirmed by the manager due to budget limitations.

- Staff in general outpatients told us they did not have regular one-to-one meetings, and there was a lack of time for team meetings. The latest minutes of the team meeting were from June 2015. However, we did see evidence of team meetings in ophthalmology and biochemistry, and were told how speakers attended and training took place at the monthly audit day in ophthalmology.
- We checked seven staff records in outpatients to identify if staff were compliant with medical device competencies. All seven staff had competencies reviewed in the past three years in line with the trust policy.
- Managers informed us that there was a process in place to manage poor performance and described how they had used the process in the past by developing a performance plan with employees.
- The preceptorship policy was in the process of being reviewed at the time of our inspection. In physiotherapy, new staff were assigned a mentor and given objectives.

Multidisciplinary working

- The diagnostic imaging and outpatients departments were staffed by a range of professionals working together as a multi-disciplinary team to provide a comprehensive service to patients.
- We observed nurse specialists supporting medical staff during consultations in outpatient's clinics.
- Letters were sent out from the outpatients department to patient's GPs to provide a summary of the consultation and any relevant treatment management plans.
- Outpatients therapy staff, including occupational therapists, physiotherapists, and dietetics, were working together as one team to share skills and reduce duplication of services to patients.
- In the fracture clinic regular multi-disciplinary meetings had been discontinued due to work load pressures. However, ad hoc meetings took place as required.

Seven-day services

- The diagnostic and imaging departments provided services such as blood tests, x-ray and scanning at the weekend. Interventional radiography and radiology had an on call rota in place to allow for 24/7 evening and weekend cover.
- Twenty-four hour and weekend cover was provided by the portering team and the radiology department had designated porters.
- There were no regular outpatient clinics offered at weekends but additional clinics were scheduled on occasion at weekends and evenings to reduce waiting list pressures.

Access to information

- The radiology department used a system called the picture archiving and communications system which is a nationally recognised system used to report and store patient images. The system was used across the trust and within a Cheshire and Merseyside consortium; this system allows local and regional access to images.
- Previous images could be viewed by staff and some GPs who were linked to the IT system allowing for prompt access to results.
- Staff were able to access information such as policies and procedures from the trusts intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients and diagnostic imaging worked on the principle of implied consent.
- Staff were given a leaflet that included the Mental Capacity Act (2005) as part of safeguarding e-learning to use as reference. Staff told us that the medical staff perform mental capacity assessments and we saw evidence in the urology clinic that capacity was documented in a medical record.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services caring?

Good

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

Staff responded compassionately when people needed help and additional support.

Patients felt supported and say that staff cared about them. Staff involved patients and those close to them in aspects of their care and treatment. Patients we spoke with during our inspection were positive about the way they were treated.

Compassionate care

- We observed five patients in their outpatient's consultation being treated with dignity and respect. Staff were polite, helpful and friendly towards them. This is supported by the patient-led assessments of the care environment (PLACE) audit for 2013 and 2014 which showed that the trust achieved higher than the national average for treating people with dignity and respect.
- All consultations and patient examinations took place in a closed consultation room. Measures had been taken in x-ray reception to allow service users to speak to the receptionist without being overheard.
- We spoke to six patients in outpatients and they told us they were pleased with the way they were treated. Patients we spoke with told us that staff always introduced themselves, and gave advice how to contact the service if they had any concerns following their appointment. We saw this happening in practice.
- We saw a receptionist offer a patient assistance to their transport after the patient said that they felt unsteady. A member of staff was made available to walk with the patient to their transport.
- We observed ten patients in the main entrance to the hospital being supported by three different staff who were directing patients and escorting them to departments. One patient said "I wouldn't change anything" and described staff as supportive.
- There were notices on the walls in clinics informing patients that there was a chaperone service if they wanted to use it.
- Our discussion with staff and review of incident reporting records confirmed that staff were aware of how to raise concerns in relation to abusive and disrespectful behaviour.

Understanding and involvement of patients and those close to them

- One patient told us they were given information, options, and choices to enable them to make informed decisions about their care and we observed five patients being informed about their care and treatment during their consultation.
- We spoke to five patients who all told us that they had been given information how to contact the service if they had any concerns when they left the clinic.
- We saw in ophthalmology posters on the wall informing patients how to contact the patient relations team as well as external support groups. Friends and family forms were provided in the departments we visited, with boxes available in the waiting rooms to submit feedback.

Emotional support

- The trust had clinical nurse specialists available for patients to talk to about their condition and to support the patient if they were being given a new diagnosis. Clinical nurse specialists were present during the consultations with medical staff.
- Staff were able to describe to us how they have provided patients with a private area to wait in or have escalated their appointment if they see a patient is becoming distressed or anxious.
- There was information available in clinic areas regarding how to access support and network groups within the community for patients with a specific diagnosis and their families. This had the potential to encourage patients and their partners to be involved in their care and decision-making and access practical and emotional support.

Are outpatient and diagnostic imaging services responsive?

Outpatients and diagnostic imaging

Requires improvement

Outpatient services across the whole trust did not consistently achieve the national target for people waiting for treatment. In addition, the trust consistently did not meet their own internal timescale targets for reporting on urgent diagnostic tests.

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

Equipment failure had resulted in patients experiencing longer waiting times in clinic, or having to return to the hospital due to rescheduled appointments.

In the fracture clinic we observed patients waiting over an hour for their appointments. The ophthalmology department waiting areas were overcrowded with insufficient room for patients with poor mobility.

Services were planned to meet patient's needs and additional clinics were scheduled as waiting list initiatives. Complaints were dealt with at service level where able, and information on how to raise a complaint was readily available across the outpatients and diagnostic imaging services. Complaints were managed within the trust time frame.

Service planning and delivery to meet the needs of local people

- We observed clear signposting through the hospital to the outpatients, diagnostic and imaging departments.
- Clear information was available in the x-ray department in relation to treatment and the process that would be followed. Information could be provided by telephone to reassure patients in diagnostic imaging services if required.
- Waiting areas in ophthalmology were overcrowded at times and we noted that there was little room for patients with restricted mobility. As part of our visit, we observed a patient in a wheelchair being placed on the corridor to wait. The manager in ophthalmology informed us that the trust had agreed to provide additional finance to improve the clinic areas.
- The main x-ray had limited seating and the area also provided access to the accident and emergency department. At the time of our inspection seating was available. However, the area may present difficulties for patients with restricted mobility.
- There was access to toilets and water fountains in the outpatient waiting areas. The water fountain had been removed from the x-ray department due to spillage and increased risk of slips and falls but there were other facilities such as a shop and café close by.
- Patients we spoke to during our inspection raised consistent issues associated with parking at the hospital.

Access and flow

- Clinics and diagnostic appointments were planned to meet both the needs of patients and national referral to treatment targets.
- National targets to achieve 95% for patients on non-admitted pathways were not achieved for July 2015 and August 2015 with the lowest being 93.5% in August 2015. However, the trust did meet the target across the trust as a whole from April 2015 to June 2015. Non-admitted pathways covers those patients whose treatment started during the month and did not involve admission to hospital.
- In the period April 2014 - March 2015 the trust met the target for 93% for patients to be seen by a specialist within two weeks of an urgent referral for concerns about cancer.
- From April 2014 to April 2015, the trust performed worse than the England average for the percentage of people waiting less than 31 days from diagnosis to first definitive treatment. However, for the same period, the trust performed better than the England average for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment.
- The national target for referral to non-urgent radiology diagnostic tests to be undertaken is six weeks. This target was consistently met across the whole trust between September 2014 and August 2015 and the trust's performance was better than the England average.

Outpatients and diagnostic imaging

- In the period May 2015 to August 2015 over 90% of routine radiological tests such as plain film x-rays were reported in the required timeframe. However, in the magnetic resonance imaging (MRI) department, routine reporting times were significantly lower falling to 24% in July 2015.
- The trust had an internal target to report 98% of urgent radiology tests within a defined timescale from referral. The timescale was different for each and was determined by the type of radiology test required. In the period April 2015 to August 2015 the trusts internal reporting target was not achieved for x-ray, computerised tomography (CT) scans, ultrasound or MRI scans. Performance for reporting of urgent MRI scans ranged from 64% in April 2014 to 67% in August 2015. We saw evidence in one patient's medical record that the patient had waited a month for urgent CT scan results. The radiology manager advised that a staffing review was in progress in the CT, ultrasound and MRI departments.
- The 'did not attend' (DNA) rates across the whole trust for outpatients and diagnostic services were lower than the national average for January 2014 to April 2015. However, the external figures did not include physiotherapy. When physiotherapy figures were included the DNA rate increased from 9.1% to 9.4% at January 2015. This was mainly due to follow up appointments being booked 12 months ahead, which were then cancelled and rebooked because a clinician's availability could only be confirmed six weeks in advance. There was a plan in place to introduce a partial booking system with the aim of reducing DNAs and improving clinic slot utilisation. The partial booking system is intended to allow patients more choice to access care and treatment at a time to suit them.
- Additional clinics were scheduled to improve access to clinics for patients in a timely manner.
- Appointments were observed to be running on time in radiology and during our inspection a patient that attended following a GP referral was seen promptly. However, during our inspection we also observed patients waiting over an hour for their appointments in fracture clinic. Patients were informed of waiting times and staff told us they performed 'comfort rounds'. We saw a 'comfort round' take place, which involved staff checking that patients were kept informed regarding waiting times and that they were comfortable.
- Patients in the cardiology clinic used a pager system which enabled them to leave the department and be called when their appointment was due to take place.
- Patients that needed ambulance transport were prioritised when clinics were running late.
- There were a number of rapid access outpatient services in the trust including ophthalmology, chest pain, medicine for the elderly, urology and endocrinology in response to more urgent patient need.

Meeting people's individual needs

- Staff described how people in vulnerable circumstances were accommodated in the department and their appointment could be escalated if required.
- We observed a dedicated support worker, supporting patients in the waiting areas in the ophthalmology clinic. Staff described how vulnerable patients such as patients with dementia, were accommodated in the department so they were seen as soon as possible.
- We saw a picture booklet that was available to assist patients living with a communication difficulty to communicate using pictures.
- We did not see evidence of an induction loop for patients with hearing problems in clinic areas.
- Access to interpreting services could be arranged by telephone or if staff were alerted to an individual patient's requirements. Interpreters could be booked in advance however we did not see this system in use during our inspection. The patient electronic booking system prompted patients to choose which language they wanted to use for the process.
- Leaflets were available at the entrance to the general outpatients clinic however, we found 'information for staff, patients, and relatives about Clostridium difficile', 'healthy eating for diabetes', 'copying letters to patients' all to have exceeded their review date which may result in patients and carers not receiving the most up to date information.

Learning from complaints and concerns

- Leaflets advising how to complain were available in x-ray reception and information on the patient advocacy and liaison service was available.
- Clinical governance meetings were held in radiology and there was evidence that complaints were discussed and reviewed in meeting minutes.

Outpatients and diagnostic imaging

- Initial complaints were dealt with by the clinic managers in the outpatients departments who resolved them locally where possible. Staff told us that most informal complaints related to long waiting times however, this was not recorded.
- During the period April 2014 to March 2015 there were 15 complaints for the clinical support division which included radiology, laboratory medicine, physiotherapy and occupational therapy. Of these complaints, 14 were closed within the trust's specified time frame. One complaint resulted in an investigation using a root cause analysis process and numerous actions were identified. Feedback to staff relating to lessons learnt was documented as part of the complaint outcome and was shared with staff at planned or ad hoc meetings, or via email from the service leads.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

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

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

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

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

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

There was a strong culture of team working across the areas we visited and staff continued to offer additional hours to meet service demand. Teams worked well locally but some staff were not formally made aware of key issues following complaints, incidents and audits.

Vision and strategy for this service

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

Governance, risk management and quality measurement

- Radiology departments should have a radiation safety committee which meets at least annually. The principle function of this committee is to ensure that clinical radiation procedures and supporting activities in the trust are undertaken in compliance with ionising and non-ionising radiation legislation. We saw evidence that the last formal meeting was held in September 2012. However, at the time of our inspection it was recognised the current radiology manager had been in post for less than twelve months and had identified that radiation safety committee meetings should resume. We were advised that the committee was set to meet in October 2015.
- Clinical governance meetings were held in radiology to review risks, incidents and complaints and to identify trends.
- The outpatients and diagnostic service departments recorded risks on the trusts central and departmental risk registers. There was one risk recorded on the department risk register at July 2015. The risk identified related to patients not being able to get through on the telephone to book an appointment. This had been on the register since May 2012 and had a review date identified for August 2015. We observed action plans with timeframes on the risk register and changes that had been completed to date.
- A weekly bulletin was available for staff to read in the staff room in the outpatients department. Outpatient specific information was available via the team meetings.
- We saw that staffing shortages in haematology had been on the risk register since 2013 and a shortage of sonographers had been on the register since 2012 however, there was a national shortage of sonographers that was having a negative impact on recruitment.

Outpatients and diagnostic imaging

Leadership of service

- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.
- Staff felt supported by their local managers but said that the trust executive team were not visible.
- In general outpatients, team meetings did not always take place and the last available minutes were from June 2015. However, bulletins were available in the staff rooms for staff to read.
- In fracture clinic the staff told us that the manager gives them a printed update of things they need to know with their payslip.

Culture within the service

- There was good team working in most areas of the departments but staff told us that staff shortages and increase in service demand had impacted on morale.
- Results of the 2014 NHS Staff Survey showed that 72% of staff felt satisfied with the quality of work and patient care they are able to deliver compared to 78% nationally. Despite this, staff continued to work additional hours in clinic areas to support a reduction in waiting times.
- When we asked staff what they were most proud of, the majority said team working and how staff supported each other.
- Divisional directors said they were most proud of the staff and their responsiveness to other services and how they cope with competing demands.

Public engagement

- Friends and family test questionnaires were readily available throughout the outpatients and diagnostic imaging departments.

Staff engagement

- 'Listening into action' team meetings were held within biochemistry. We saw minutes of meetings and staff reported positive action in response to them.
- Staff reported that weekly emails were received from the Chief Executive and that their ideas and suggestions could be voiced. However, one staff member reported a mixed response when doing this and another reported a delay in receiving a response.

Innovation, improvement and sustainability

- We observed plans in place in the biochemistry department to provide second year medical students the opportunity to visit the laboratory to observe the process for managing and analysing samples to reduce future errors when requesting diagnostic tests.
- The Ophthalmology department were looking to develop a pathway for patients with glaucoma to enable patients to be treated in the community were appropriate. The intention was to reduce waiting times and enable patients to be treated closer to home.
- We observed minutes from the project governance meetings ranging from March 2015 to September 2015 which provided regular updates about ongoing initiatives for service development including the partial booking system.

Outstanding practice and areas for improvement

Outstanding practice

- Senior clinicians on the emergency surgical assessment unit had recognised that fluid balance monitoring could be improved and introduced a training programme for health care support workers to achieve this aim. Health care support workers told us they felt empowered by the training and saw fluid balance monitoring as an integral part of their role after it. Audits showed that the completion of fluid balance charts had improved since the training and senior clinicians reported that there had been a significant reduction in the number of patients developing acute kidney injuries (a condition associated with dehydration).
- The sentinel stroke national audit programme (SSNAP) latest audit results rated the trust overall as a grade 'A' which was an improvement from the previous audit results when the trust was rated as a grade 'B'. Since October 2014 the trust had either been ranked first or second regionally in the SSNAP audit.

Areas for improvement

Action the hospital MUST take to improve

Urgent and emergency care

- Ensure call bells are available in every bay and placed with patients.
- Staffing continues to remain a focus and that shifts are adequately staffed to meet the needs of patients.
- Ensure that risks are always managed and mitigated in a timely way.

Medical care (including older people's care)

- The trust must ensure that robust information is collected and analysed to support improvements in clinical and operational practice.
- The trust must ensure that care and treatment is only provided with the consent of the relevant person and if a patient lacks capacity to consent, the Mental Capacity Act (2005) principles are adhered to. This must be supported by staff receiving training in consent and the principles of the 2005 act.
- The trust must deploy sufficient staff with the appropriate skills on wards, especially on the medical short stay ward and on ward 16 at night.
- The trust must ensure that learning is shared across all service areas and the reasons for any changes made clear to all staff.
- The trust must ensure that records are kept secure at all times so that they are only accessed and amended by authorised people.

Surgery

- The trust must ensure that there are adequate numbers of suitably qualified staff in theatre recovery areas to ensure safe patient care.
- The trust must ensure that all staff involved with the care and treatment of children receive adequate life support training.
- The trust must ensure that all staff receive are appropriately trained and able to use the incident reporting system.

Critical care

- The trust must address the governance shortfalls in critical care and make sure that the systems and processes in place for assessing, monitoring and mitigating local risk are managed effectively.
- The trust must ensure that all staff understand the thresholds for reporting incidents and are encouraged to use the electronic reporting system.
- The trust must make sure that all staff understand and comply with the best practice in infection prevention and control. This includes appropriate use of handwashing and the use of antiseptic hand gels.

Outstanding practice and areas for improvement

Maternity and gynaecology

- Review the management of the electronic rostering system to ensure it does not allow staff to be rostered on different wards at the same time.
- The provider must deploy sufficient clinical and midwifery staff with the appropriate skills at all times of the day and night to meet the needs of women following the trust risk assessment and escalation procedures.
- The provider must ensure that there is a detailed overview of the types and seriousness of incidents and learning is shared across all service areas and the reasons for any changes made clear to all staff.
- The provider must make sure individual care records are always accurate and completed contemporaneously.
- The provider must make sure community midwives have easy access to the emergency medication and equipment detailed in best practice guidance. The equipment must be checked and items provided within the use by date.

Children and young people's services

- Resuscitation trolleys must be appropriately checked and the log book must be signed to confirm all items are in working order. The trolley must include a defibrillator at all times.
- Must ensure that there is a robust system to determine staffing numbers which takes into account the acuity of patients and skill mix of staff.
- Information must be collected and analysed to support developments in clinical and operational practice.
- Must review the children's safeguarding training to ensure it meets Royal College of Paediatrics and Child Health (RCPCH) guidelines 2014.

End of life

- Ensure that any complaint received is investigated and necessary and proportionate action is taken in response to any failures identified by the complaint or investigation.
- Seek and act on feedback from relevant persons and staff teams, for the purpose of continually evaluating and improving services.
- Evaluate and improve their practice in respect of the processing of information relating to the quality of people's experience.
- Ensure there is a robust vision and strategy for end of life services and all staff are aware of them.
- Ensure that there is an appropriate replacement care plan in place across the trust following the withdrawal of the Liverpool Care Pathway.
- Ensure that all risks associated with end of life services are recorded and monitored with appropriate actions taken to mitigate them.

Outpatients and diagnostics

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

Action the hospital SHOULD take to improve

Urgent and emergency care

- Review and introduce regular audits of patient records to ensure all relevant details are correctly sourced and recorded.
- Take action to address waiting times and the access and flow through the hospital.
- Review and evaluate the outcomes from use of the potential sepsis warning tool.

Medical care (including older people's care)

- The trust should ensure that hazardous chemicals are stored appropriately in a locked cupboard when not in use.
- The trust should ensure that the acuity of patients on the coronary care unit is regularly assessed to ensure there is an appropriate skill mix of staff.

Outstanding practice and areas for improvement

- The trust should ensure that trolleys used to store records and sharp instruments are kept secure when not being used.
- The trust should ensure those patients are discharged as soon as they are fit to do so.
- The trust should ensure that patients are not moved ward more than is necessary during their admission and are cared for on a ward suited to meet their needs.
- The trust should ensure that patients' views are sought to help inform changes to services provided.
- The trust should ensure that actions to improve standards of medicines management are identified in a timely way.
- The trust must consider implementing formal procedures for the supervision of staff to enable them to carry out the duties they are employed to perform.

Surgery

- The trust should ensure that the emergency surgical assessment unit is not used for medical outliers.
- The trust should ensure that patients are not kept in theatre recovery areas for long periods of time or overnight.

Critical care

- The trust should ensure that all equipment is regularly serviced, maintained and remains fit for purpose.
- The trust should ensure that all patient records are accurate and fit for purpose.
- The trust should ensure that any delayed discharges from critical care do not result in a breach of the government's single sex standard.
- The trust should consider developing to plans to indicate when facilities will be upgraded to comply with the current HBN 04-02. It is imperative that critical care is delivered in facilities designed for that purpose.
- The trust should consider how it is going to improve performance in reducing the number of delayed and out of hours discharges of patients from critical care.
- The trust should consider articulating a vision and strategy for the critical care service and communicating this to its staff.

Maternity and gynaecology

- The provider should ensure women and babies who are subject to safeguarding or child protection concerns have their needs reviewed before they are discharged from the maternity service.
- The provider should consider making it possible for all staff to be able to complete incidents directly onto the system
- The provider should make sure the arrangements for managing medicines and medical gases keep people safe and meet the relevant best practice guidance.
- The provider should ensure the general public are given opportunities to comment on their strategic plans.
- The provider should consider providing written information in different languages.
- The provider should consider maternity and gynaecology working more closely together so that effective systems can be shared.
- The provider should consider ways of improving staff satisfaction with working for maternity services at Arrowe Park Hospital.

Children and young people's services

- The patient electronic system in the emergency department should include a safeguarding identifier to inform staff of known safeguarding concerns.
- The trust should consider adding a paediatric nurse to the trust wide safeguarding team.
- A robust development plan should be in place to improve staff skills.
- The cot space on the neonatal ward should meet British Association of Perinatal Medicine (BAPM) standards.
- There should be more integrated working between the wards and the children's assessment unit.

Outstanding practice and areas for improvement

- All equipment in all areas of the children ward, neonatal unit and the children's assessment unit should be tested for electrical safety and all plug sockets should have safety plugs.
- There should be an active board level representative for children and young people's services.

End of life

- Ensure policies and protocols are reviewed and monitored regularly to ensure their effectiveness and implementation is consistent across the trust.

Outpatients and diagnostics

- The trust should take steps to ensure that equipment is available and fit for use with minimal disruption to the service.
- The trust should ensure that medication is not left unattended when not in use.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 11: Consent **How the regulation was not being met:** Care and treatment was not always provided with the consent of the relevant person. This is because the consent for a procedure had not been documented in a patient record we reviewed on ward 14. In addition, the bed rails assessment did not include the recording of consent to the use of bedrails or best interest decisions for patients who lacked capacity to consent. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 11(1)(3).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12: Safe care and treatment. **How the regulation was not being met:** The emergency department did not include arrangements to respond appropriately and in good time to people's changing needs. This is because we found that call bells were either out of reach of patients, or not installed at the bed side of patients in the 'trolleys' area of the emergency department.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 13: Safeguarding service users from abuse and improper treatment. **How the regulation was not being met:** Safeguarding children's training was not provided in line with best practice guidance.

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

How the regulation was not being met:

The service was not doing all that was reasonably practicable to mitigate the risks to service users.

This is because a resuscitation trolley on a paediatric ward was not checked regularly and it contained out of date equipment and there was no defibrillator present.

Also, there were also lengthy delays in the reporting of urgent diagnostic test results.

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

How the regulation was not being met:

Care and treatment was not always carried out assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated.

This is because not all staff in critical care were washing their hands or using antiseptic hand gel as appropriate when delivering patient care or moving from one patient or their bed space to the next.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12 (2) (h)

This section is primarily information for the provider

Requirement notices

This is because children's safeguarding training did not meet Royal Children's Paediatric Child Health (RCPCH) guidelines 2014.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 13 (2).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 16: Receiving and acting on complaints. **How the regulation was not being met:** The registered person did not establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. This is because complaints were raised in relation to the timely completion of death certificates but the trust had not taken any action to address this at the time of the inspection. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 16 (2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17: Good Governance. **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Systems and processes were not always operated effectively to ensure that the risks relating to the health, safety and welfare of service users and others were assessed, monitored and mitigated in a timely way.

This is because the systems and processes for managing local risks did not always assess, monitor and mitigate risks such as patient transfer equipment, which did not meet the current Intensive Care Society standards for the transport of critically ill adults. In addition, all departments had a risk register but the risks were not always managed and mitigated in a timely way.

This is also because radiation safety committee meetings were not being held at least annually.

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

How the regulation was not being met:

Records were not always secure, accurate or completed fully.

This is because record trolleys were left unlocked on some of the medical wards we visited. In addition, we reviewed a sample of 23 patient records in the emergency department and found that 19 were not fully completed. For example, pain scores were missing in six records, initial observations were missing in three records and information relating to safeguarding and social circumstances was not recorded in five records. In addition, the electronic record keeping system in maternity did not ensure records were always complete and contemporaneous in respect of each service user.

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

How the regulation was not being met:

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

This section is primarily information for the provider

Requirement notices

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

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

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

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

How the regulation was not being met:

There were insufficient systems or processes established and operated in maternity to effectively ensure a robust response by staff to the guidance provided and action required to mitigate risks.

This was because of ineffective staff rostering, staffing escalation process; poor implementation of the ward safety alert protocol; insufficient implementation of changes in best practice guidance from lessons learnt from incidents or root cause analysis.

In addition, community midwives did not have easy access to emergency medication and equipment detailed in best practice guidance. The equipment must be checked and items provided within the use by date.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18: Staffing **How the regulation was not being met:** There was not a systematic approach to determining the staff and range of skills required.

This section is primarily information for the provider

Requirement notices

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

This is because the systems to determine staffing levels in maternity and children's and young people's services were not robust.

There were shortages of nurses, midwives and medical staff in several areas throughout the hospital, particularly in the emergency department, maternity, medical care services, children and young people services, surgical services and radiology.

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

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