Wrightington, Wigan and Leigh NHS Foundation Trust

Evidence appendix

The Elms, Royal Albert Edward Infirmary
Wigan Lane
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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Acute and community sites at the trust

A list of the locations providing acute services at Wrightington, Wigan and Leigh NHS Foundation Trust is below.

Location site name	Address	Details of services provided
Royal Albert Edward Infirmary	Wigan Lane, Wigan, WN1 2NN	Emergency, critical care, medical (including older people), surgery, paediatric, neonatal, maternity, end of life, cancer.
Leigh Infirmary	The Avenue, Leigh, WN7 1HS	Medical (including older people), surgery (99% day case and 1% elective), maternity and gynaecology and outpatient and diagnostic imaging (including urology, renal, anti-coagulation, cardiology, chest, obstetrics and gynaecology).

Wrightington Hospital	Hall Lane, Appley Bridge, Wigan, WN6 9EP	Specialist orthopaedic hospital. Surgery (orthopaedic, hip replacement and revision and joint replacement), rheumatology, outpatient and diagnostic care is provided for patients.
Thomas Linacre Centre	Parsons Walk, Wigan, WN1 1RU	Outpatient clinics for: anti-coagulation, cardiology, haematology, diabetes, breast biopsy, endocrinology, gastroenterology, hepatology, nephrology, surgery, oncology, plastics, rheumatology, ENT, pain, urology and diabetes. There are also three mobile screening units for the breast screening service which is also based on this site.
Boston House Eye Unit	WWL Eye Unit, Wigan Health Centre, Boston House, Frog Lane, Wigan, WN6 7LB	The trust's base for ophthalmology services. It provides outpatient treatment, screening and diagnostic eye services. It is a stand-alone outpatient clinic occupying two floors within Wigan Health Centre.
Wilmslow Health Centre	Chapel Lane, Wilmslow, SK9 5HX	The provision of an Orthopaedic Carpal Tunnel Service. The Trust is registered for surgical procedures at this location.

In April 2019 the trust acquired community health services in the borough of Wigan from Bridgewater Community NHS Trust. These include services for adults and children and the walk-in centre at Leigh infirmary.

A list of the locations providing community services at Wrightington, Wigan and Leigh NHS Foundation Trust is below.

Location site name	Details of services provided
Alexander Court	Community therapy team
Ashton Clinic	Health visiting, heart failure nurse, podiatry, tissue viability, treatment room, cancer/palliative care hospice, cardiac rehabilitation, continence service/paediatric & CYP dietetics.
Aspull Clinic	Health visiting, podiatry, treatment room.
Astley Clinic	Podiatry, school nursing.
Atherton Health Centre	Community, nutrition support service, & diabetes dietetics, continence service, paediatric & CYP dietetics, district nursing, health visiting, podiatry, treatment room.
Boston House Health Centre	Cancer/palliative care hospice, cardiac rehabilitation, cardiology, community nutrition support service & diabetes dietetics, community matrons, counselling team, dermatology, district nursing, heart failure nurses, MSK physiotherapy, MSK CATS (clinical assessment & treatment), palliative care, paediatric dietetics, physiotherapy, podiatry, respiratory, school nursing, treatment room.
Chandler House Health Centre	Adult learning disabilities, cancer palliative care hospice, counselling team, complex care, district nursing, podiatry, treatment room.

Claire House Health Centre	Child protection, children's complex needs, children's specialist nursing, community children's nursing, community matrons, counselling team, district nursing, district nursing evening and weekend, falls office, falls, fracture clinic, safeguarding team, treatment room, district nursing out of hours.
Golborne Clinic	Paediatric audiology, chronic fatigue, nutrition support services, diabetes, dietetics, continence service, paediatric & CYP dietetics, counselling team, district nursing, health visiting, neuroscience, newborn hearing screening, podiatry, school nursing, speech & language therapy (adult) treatment room, physiotherapy.
Hindley Health Centre	Continence service/paediatric & CYP diabetes, counselling team, district nursing, podiatry.
Hindley Town Hall	Base 0-19 services, admin support, community matrons, community therapy team, district nursing, health visiting.
Ince Clinic	Podiatry
Leigh Health Centre	Urgent care walk-in centre, community nutrition support service & diabetes dietetics, continence service, paediatric CYP dietetics, counselling team, district nursing, MSK physiotherapy, MSK CATS, occupational therapy, physiotherapy, podiatry, treatment room.
Leigh Infirmary	Adult learning disabilities, cardiology, community matrons, continence service/paediatric & CYP diabetes, community therapy team, district nursing, intermediate care, mobility care, neuroscience, occupational therapy, paediatric diabetes, physiotherapy, speech & language therapy adults/paediatrics, surgical appliances.
Leigh Sports Village	Base community teams
Longshoot Health Centre	Continence service/paediatric & CYP diabetes, counselling team, homeless/vulnerable team, neuroscience, podiatry, speech & language therapy (SEN).
Old Henry Street Surgery	Counselling team
Pemberton Health Centre	Continence service/paediatric & CYP diabetes, counselling team, community therapy team, district nursing, homeless/vulnerable team, physiotherapy, podiatry, falls, school nursing, TB service, treatment room.
Platt Bridge Health Centre	Audiology, paediatric audiology, children's learning disability team, children's nursing manager, continence service/paediatric & CYP diabetes, counselling team, community therapy team, health visiting, MSK physiotherapy, MSK CATS, neuroscience, newborn hearing occupational therapy, paediatric physiotherapy and OT, podiatry, safeguarding team, speech and language therapy adults/paediatrics/SEN, treatment room.
Shevington Clinic	Counselling team, family nurse partnership, health visiting, podiatry, treatment room.

Standish	Continence service/paediatric & CYP diabetes, district nursing, podiatry, falls, treatment room.
Tyldesley Health Centre	Counselling team, health visiting, podiatry, treatment room.
Wigan Life Centre	Base for community district nurses and health visitors

(Source: Trust Website / Routine Provider Information Request (RPIR) – Sites tab)

Is this organisation well-led?

Leadership

The trust had a unitary board which consisted of executive and non-executive directors. The board was made up of the following members:

- Chair
- Chief executive
- Chief nurse
- Chief operating officer
- Finance director and deputy chief executive
- Medical director
- Strategy and planning director
- Workforce director
- Seven non-executive directors

Board Members

Of the executive board members at the trust, 6.7% were Black and Minority Ethnic (BME) and 20.0% were female.

Of the non-executive board members 0.0% were BME and 13.3% were female.

Staff group	BME %	Female %
Executive directors	16.7%	20.0%
Non-executive directors	0.0%	13.3%
All board members	6.7%	33.3%

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

Since the last inspection the trust had appointed a new chief executive and new chief nurse following the retirement of the previous chief executive and chief nurse. The new chief executive started at the end of October 2019 and had experience working in chief executive roles at other NHS trusts. The new chief nurse started in August 2019 and had previously held chief nurse roles at NHS trusts and a clinical commissioning group. All of the other executive directors were in post at the last inspection and had previously worked in other roles at the trust before being appointed to the board.

Five of the seven non-executive directors had changed since the last inspection, three of the posts were due to directors coming to the end of their appointment and two were unplanned due to the sad deaths of two non-executive directors. The trust had extended the appointment of one of the non-executive directors for an extra year, to create stability while new non-executive directors were appointed.

We found the trust executive leadership team had an appropriate range of skills, knowledge, experience and commitment. While it was the first board level appointment for five of the executive directors, their development had been supported. The performance of the executive leadership

team was reviewed and monitored through an annual appraisal process to ensure that they maintained the skills, knowledge and integrity to carry out their roles.

Non-executive directors had a varied range of skills, knowledge, and experience to challenge, support and scrutinise board decisions and actions. They had worked in leadership and senior management positions in the NHS, accountancy, academia, public sector and in private organisations. The recruitment process for non-executive directors was led by the elected trust governors. Ahead of the recruitment for new non-executive directors, the non-executives and governors met to identify skill-sets that would meet strategic priorities. It had been identified that a non-executive director from the university the trust had links with and a non-executive director with community experience were priorities for recent and forthcoming appointments. Non-executive directors' performance was reviewed by an annual performance development review process by the chair, and the senior independent director for the chair.

Executive director's portfolios appeared to be balanced and directors had deputies in post to support them with the delivery of their portfolio. The non-executives had addition lead roles for safeguarding; communications; maternity; and raising concerns. One of the non-executive directors was also appointed as the senior independent director and another as the freedom of information independent reviewer.

At the last inspection the trust had identified that board members' capacity was an issue due to the volume of work, particularly with increased demands of their roles, in connection with the future partnership plans for the trust. Following that inspection, the trust had made changes to portfolios and responsibilities to support the strategic work. While leaders did not articulate that it had been a recent concern, this was highlighted as an area to keep under review. The trust was in the process of recruiting a chief allied health professional who would report to the chief nurse to strengthen engagement with and leadership of allied health professionals and support new workforce models.

The medical director, associate medical director and divisional medical directors carried out clinical roles in addition to their director roles. Since the last inspection the medical director had reduced their clinical role from 50% of their time, although still carried out approximately 30% of their contracted time in a clinical role. The trust had identified capacity of medical leadership as an area to review ensuring that medical leaders had sufficient time to complete their roles.

Board members articulated the importance of the visibility of leaders across the trust. The board had monthly planned walkabouts where an executive director, non-executive director and governor would visit a ward or area of the trust and speak to staff and patients. In addition, the chief executive, medical director and chief nurse had weekly walkabouts at Royal Albert Edward Infirmary starting in A&E and visiting other areas at the hospital. As well as the planned visits directors carried out unplanned visits across the trust. Staff we spoke with across the trust during our core service inspection had mixed views about the visibility of senior divisional and trust wide staff. Staff in the areas we inspected said that senior leaders were not always visible.

Existing and aspiring leaders had access to a range of leadership development programmes and other learning and development opportunities. Since the last inspection the trust had developed a leadership behavioural framework which set out the expectations of leaders. The board had previously had board development sessions although these had stopped since the last inspection. The trust was planning to re-start board development and was starting with an externally facilitated session on personalities and board chemistry.

The trust ran leadership programmes accredited to the Chartered Management Institute at different levels. Between July 2018 and June 2019 290 members of staff had participated in a leadership development programme, this had increased significantly from the preceding years

when 144 and 104 members of staff had participated. Aspiring and practicing leaders were also able to access NHS Leadership Academy programmes or enrol on a coaching and mentoring development programme, also accredited to Chartered Management Institute. At the time of the inspection the trust did not have a dedicated leadership development programme for consultants although was looking to start a programme to support them into clinical director or other medical leadership roles. Leaders from Black and Ethnic Minority backgrounds were offered the opportunity to attend the NHS Leadership Academy 'Stepping Up' programme.

The non-executive directors carried out annual succession planning for the executive roles. For each of the roles they reviewed the suitability of deputies as replacements in the short and long term. As a result, the chair and non-executives had a good understanding of areas for development and potential gaps. This succession planning fed into the annual performance development review process in order to identify learning and development needs for staff identified as future board members.

The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. The trust had a fit and proper person's procedure for all executive and non-executive directors. The procedure detailed the requirements for new directors and an annual self-assessment for existing directors. We reviewed a sample of personnel files for executive and non-executive directors and found the appropriate checks had been carried out to ensure that they were compliant with the regulation.

Vision and strategy

The trust had a vision to be in the top 10% of everything it does and a mission to provide the best possible health care for all its patients. The values and strategy were represented by the 'WWL Wheel' which had been used by the trust for a number of years as a visual representation of the vision and strategy. At the centre of the wheel was the trust's quality strategy to be safe, effective and caring. This was surrounded by the behaviours: compassionate, respectful, accountable, collaborative and forward thinking. The wheel was underpinned by the four corporate objectives: patients; people, performance; and partnerships.

In 2019 the trust started the process of updating its strategy for 2019-2024. Following consultation with staff, patients and stakeholders, the high level strategy was approved at the trust board meeting in July 2019. The corporate objectives and behaviours remained the same, but the aim was updated with new focal points and strategic priorities. Before the full strategy was shared publicly the trust decided to pause the strategy until the new chief executive was in post. Since the strategy was being refreshed there were also new leaders at the local authority and clinical commission group and a new local authority ten year strategy. The pause in the strategy was to ensure that the new chief executive had an opportunity to input into the strategy and to ensure it fully reflected wider plans for Wigan. The trust had a clear plan for implementing the new strategy in April 2020 which would involve engagement with staff, patients and stakeholders. Leaders told us that for the current year the existing strategy would be carried over until the new strategy was implemented.

The trust monitored delivery of the strategy through the board assurance framework, in which performance measures for the four corporate objectives (patients; people, performance; and partnerships) were recorded and weighted to give an overall performance score. The priorities in the existing 2014-19 strategy included: integrated care, and collaboration; physical reduction in the

size of hospital; investment in world class IT; focus on clinical service change; growth in orthopaedics; fertility, vascular and cancer collaborations; neuro-rehabilitation changes and increased commercial opportunities.

The trust continued to have a focus on partnership working with other NHS trusts, education organisations, the commissioners and the local authority. Since the last inspection the trust had focussed on working with other organisations and commissioners in the Wigan Borough to move towards more integrated provision of health and social care. This had progressed with the acquisition of community services from the community healthcare trust who had previously provided community services in the locality. While the trust was committed to the integration of services in neighbourhoods across Wigan, it saw itself as an 'anchor' institution in Wigan which reflected its broader importance, beyond providing healthcare, for example as a major employer in the area.

Leaders at the trust were active in the Greater Manchester Health and Social Care Partnership and in particular the workstream around acute transformation plans. Leaders had a clear understanding of the opportunities and risks of the changes. The trust planned to be a major provider of orthopaedic services, although understood the importance of providing core services for the people of Wigan and the risks to the delivery of core services with specialist services being realigned across Greater Manchester, for example the provision of breast services. Leaders told us that some of the longer term plans for the delivery of clinical services at the trust were affected by decisions about the delivery of acute services across Greater Manchester. This was reflected in our core service inspection where we found that not every service had a clear vision and strategy for the future, due to uncertainty about what services would be provided by the trust.

Aside from involvement in reconfiguration of services in Greater Manchester the trust continued to work with other NHS providers to collaboratively deliver services. The trust had longstanding joint arrangements with an NHS trust for the delivery of pathology and decontamination services and two NHS trusts for the delivery of occupational health services. The trust also had a joint vascular surgery rota with a neighbouring trust due to the challenges in recruiting and retaining medical workforce to staff the rota. Since 2015 the trust had hosted a satellite clinic from the regional specialist cancer centre to deliver chemotherapy and other treatment for Wigan patients closer to home.

At the time of the inspection the trust was developing a clinical service strategy. The new clinical services strategy aimed to ensure that all community and acute services currently delivered by the trust were reviewed and that each service within the trust portfolio had an agreed strategic direction. The last clinical services review took place in 2015 and informed the expansion of orthopaedic services at Wrightington and discontinuation of neuro-rehabilitation at Leigh Infirmary.

The trust had a suite of strategies which supported the delivery of the strategy including a quality strategy for 2017-2021; nursing, midwifery, therapy and care staff strategy for 2016-2021 and an inclusion and diversity strategy for 2016-2020. At the time of the inspection the trust was developing a workforce plan for the next three years.

The quality strategy focussed on five key drivers: excellence in clinical care; engagement and networking; quality improvement; measuring and monitoring safety; and culture. The trust agreed annual quality priorities following consultation with staff and stakeholders including governors, the local clinical commissioning group and the local Healthwatch. In 2019-20 the trust had 11 quality priorities (four in the safe domain, four in the effective domain and three in the caring domain) with identified ways that performance would be reported and monitored. In 2018-19 the trust set 11 quality priorities and achieved five and did not achieve six.

The trust had a clear annual operation plan which set out the activity, quality, workforce and financial planning for the coming year. An operational plan is a mandatory requirement to be submitted to NHS Improvement every year. Divisions completed annual delivery plans which fed into the delivery of the operation plan and strategic objectives.

The trust's medicines optimisation strategy aimed to make medicines optimisation part of routine practice throughout the trust. A key target to achieve over 90% medicines reconciliation within 24 hours for all acute admissions by 2020 was on course to be achieved.

Culture

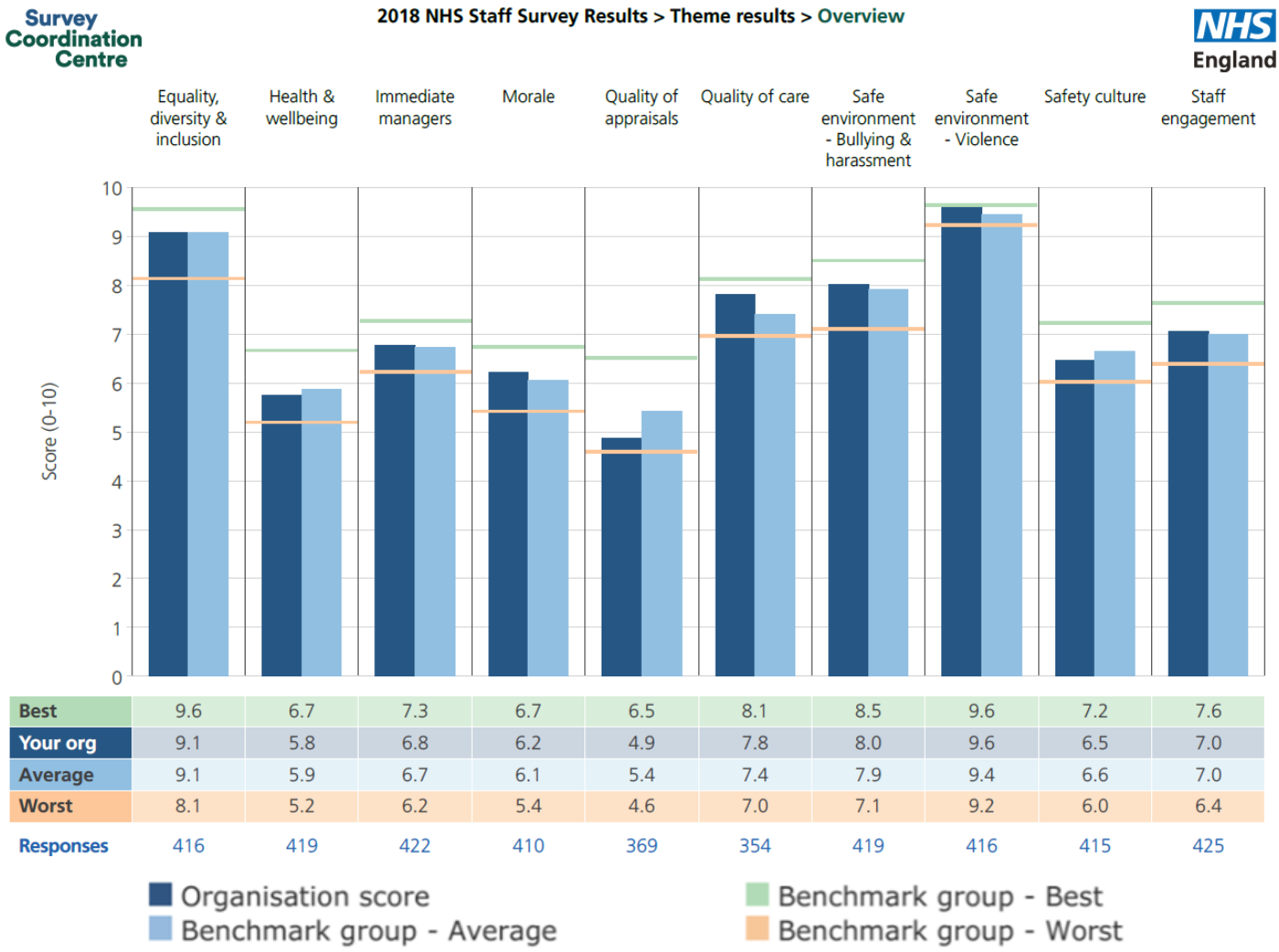
Staff we spoke with on the inspection were focussed on the needs and experience of patients. Staff generally were proud of their teams and services and felt the trust was a good place to work. Staff felt supported, respected and valued by their local leaders. Board members and other senior leaders we interviewed were passionate about their roles and the trust.

Since the last inspection the trust had started a programme of work to promote a just culture. A just culture is a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. The programme would incorporate inclusive leadership and the civility saves lives campaign as was in its early stages.

Patient experience had strong coverage at the trust board meetings and in committee meetings. At every trust board there was a patient story by video with plans for patients to present the story in the New Year. The trust carried out monthly real time patient experience surveys which were reported in the board performance report in addition to information about complaints and friends and family test. Between April and September 2019, the trust was meeting the 90% positive response target for 11 of the 13 questions. The trust was focussing on improving the questions about patient involvement in decisions and knowing the consultant.

NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.



The trust's 2018 scores for the following themes were significantly lower when compared to the 2017 survey:

Health and wellbeing

Quality of appraisals

Safety culture

Staff engagement

There were no themes where the trust's scores were significantly higher when compared to the 2017 staff survey.

(Source: NHS Staff Survey 2018)

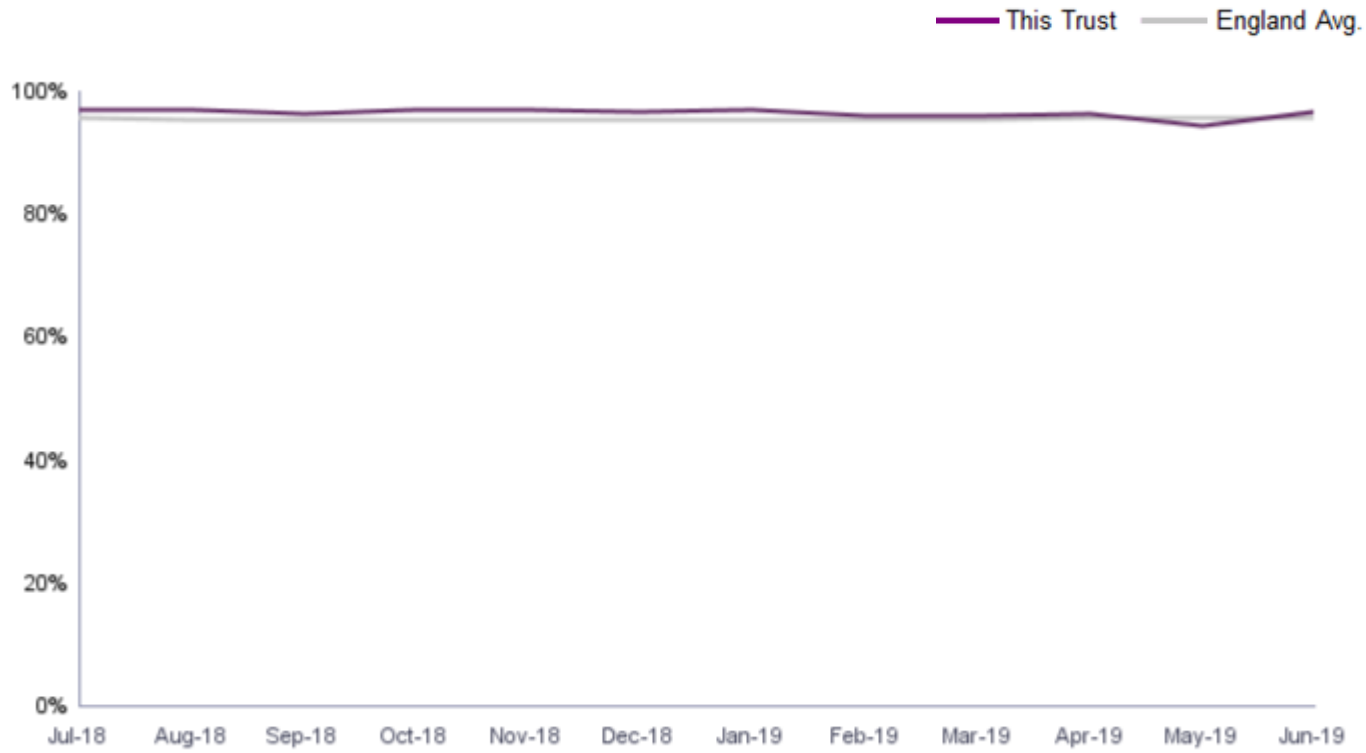
The results of the national staff survey were similar to benchmarked peers for most of the themes, although there had been some deterioration from the 2017 staff survey. There was an improved or maintained performance for 18% of the relevant questions against 2017 results and the trust was equal to or higher than national average for 61% of questions, however the margin that the trust was above the national average had lessened compared to 2017. The trust had identified that this may have been due to the impact of the setting up of a subsidiary company which had led to strike action by staff and also increased patient demand and financial pressures. The trust had an action plan to focus on the four areas which had declined: health and wellbeing; quality of appraisals; safety culture; and, staff engagement. In addition to the annual staff survey the trust carried out its

own quarterly pulse check survey using its staff engagement tool (Go Engage), aligned to the staff survey questions. As a consequence, the trust had an early indication of the staff survey results (which had fallen in quarter three of 2018-19) and started work to address the areas ahead of the results being published.

Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored either slightly higher than or about the same as the England average for recommending the trust as a place to receive care from July 2018 to June 2019.



(Source: Friends and Family Test)

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed the same as expected for all 18 indicators.

(Source: General Medical Council National Training Scheme Survey)

The trust had a guardian of safe working who had been newly appointed in September 2019. The guardian of safe working is independent of trust management and is a champion of adherence to safe working hours, oversees safety-related exception reports and monitors compliance with the system. The trust's guardian procedures were in line with national guidance with reporting to the junior doctors forum, the local negotiating committee with a statement in the trust's annual quality report. The guardian reported there were also strong links with the trust's human resources

function. The guardian reported to the workforce committee although did not directly report to the trust board which is a requirement of the role.

There was a strong commitment to provide medicines training and support for junior grades of clinical and technical pharmacy staff. Engagement with all grades of staff in the pharmacy team ensured an inclusive culture, and ideas for improvements were welcomed.

Since the last inspection the trust had developed an executive disciplinary review panel which considered all cases put forward for formal disciplinary action to ensure that it the appropriate route and that exclusions, timescales and support for staff is appropriate.

Staff we spoke with, of all levels, were open and honest. Staff we spoke with on the inspection did not raise any concerns about being unable to speak up and leaders told us there was a strong culture of openness from staff. The trust had strong links with the unions who had regular partnership forum meetings with all of the executive directors. From the board papers we reviewed we saw that where agenda items were discussed at the private board there were reasons to do so, for example because of commercial sensitivity or patients could be identified.

The trust had processes to support whistleblowers and as part of its 'speaking up' processes. The trust had appointed a freedom to speak up guardian in 2017, as an additional role to their full time job. Freedom to speak up guardians work with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety. The role of the freedom to speak up guardians had been created as a result of recommendations from Sir Robert Francis in February 2015. Before the introduction of the position the freedom to speak up guardian had been the guardian for raising concerns. Since the last inspection the trust had appointed a freedom to speak up advocate to work alongside the guardian, to assist in the investigation of concerns and provide resilience to the service. At the time of the inspection the trust was updating the freedom to speak up guardian arrangements with a business case having been approved for a full time guardian.

In the year before the inspection there had been 56 contacts to the guardian. Of the contacts 34 related to attitudes and behaviours, 15 to quality and safety, one to service change, one to policies/procedures and processes and the remaining five were unknown as full details were not provided. The trust reported that attitudes and behaviours as a theme encompassed concerns such as: relationships with colleagues, poor treatment by managers, bullying and harassment or retaliation following concerns being raised locally at service level. As a consequence of contacts, the trust had reviewed systems and processes and arranged for further support for staff from line management. The trust had strong links between the freedom to speak up guardian, human resources team and fraud specialist manager so all potential whistleblowers could be identified and action taken when needed. A joint report was provided to the board twice a year covering 'speaking up' contacts.

The trust had a being open and duty of candour policy and standard operating procedure to ensure the requirements of duty of candour were met. The duty of candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers. Since the last inspection the trust had provided training and awareness sessions to promote staff understanding of the duty of candour. In the serious incidents we reviewed we saw the trust had complied with the duty of candour requirements.

Duty of candour compliance for serious incidents was monitored in real time and through the weekly executive scrutiny committee and assurance reports to the quality and safety committee. In 2018 the trust had an internal audit of duty of candour processes and was given substantial assurance about the process. The review identified that the trust had taken steps to instil and

promote a culture of candour and openness and had processes in place for staff to raise any concerns and for them to feel safe in doing so.

For a number of years, the trust had run a Talksafe initiative for teams. The initiative is a programme focussed on changing the safety culture of an organisation through structured conversations. The conversation focuses on praising good practice and seeks to effect culture change by highlighting the potential consequences of unsafe actions.

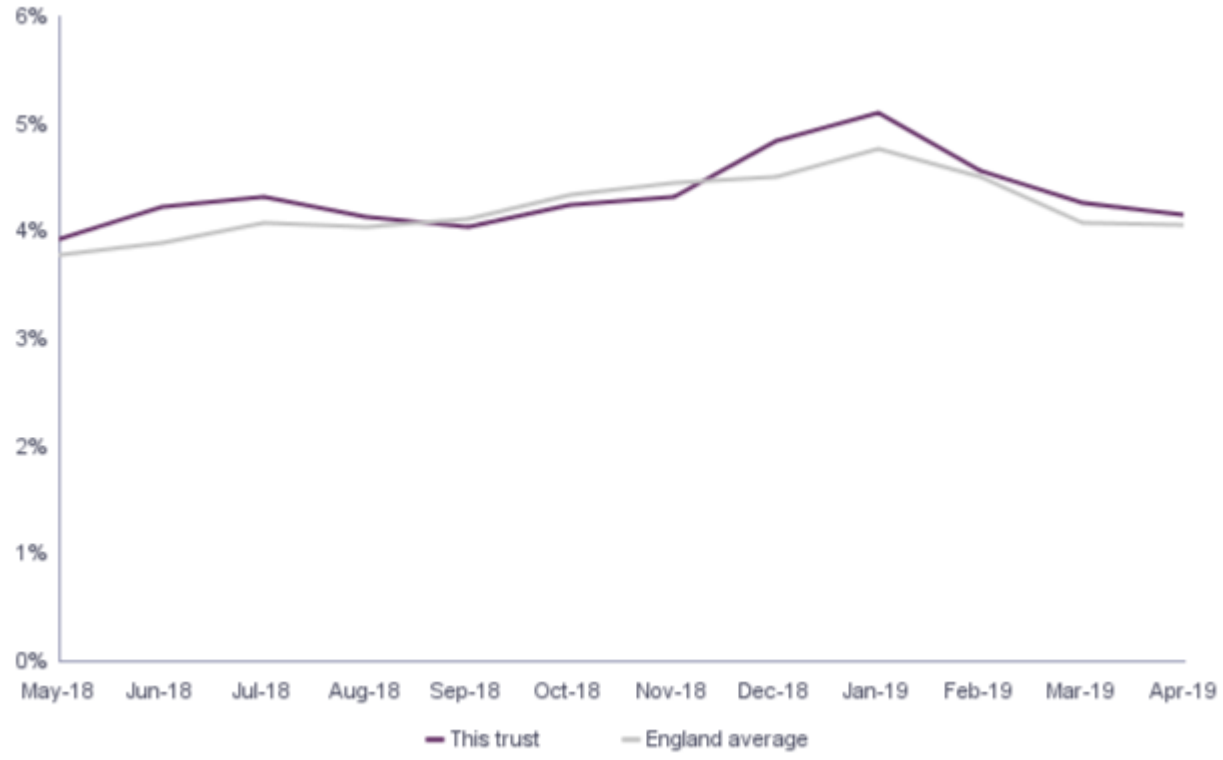
Since 2014 the trust had set standards of ten always events, which were behaviours and actions which should always happen relating to communication; personal care; nutrition; speaking up; medicines; discharge and dignity in death. These were prominently displayed across the trust.

The trust had a range of development opportunities and programmes available to staff. At the time of the inspection the appraisal rate across the trust was 83.8% (October 2018-September 2019). In the 2018 staff survey the quality of appraisals had been one of the areas which had deteriorated from the previous year. The trust escalated the risk to the corporate risk register and carried out a full review and refresh of the appraisal framework and documentation. The trust also asked the internal auditors to complete an audit of the appraisal quality.

Since the last inspection the trust had set up an educational governance committee to improve the standardisation and governance of education across the trust. As part of the new processes divisions would hold learning needs panels to identified learning needs. During the core service inspection, we identified gaps in life support training within staff groups in the surgical division. The trust had identified gaps in the oversight of face-to-face training ahead of the inspection and was in the process of reviewing it so there was better oversight and reporting.

Sickness absence rates

The trust's sickness absence levels from May 2018 to April 2019 were similar to the England average. Fluctuations in the trust's sickness levels generally followed those seen in the England average.



(Source: NHS Digital)

The trust offered a range of health and wellbeing services for staff by the trust's Steps 4 Wellness team. In 2018 the trust had won a national award for the most improved workplace at the at the Britain's healthiest workplace awards. While the trust had won that award, in the 2018 staff survey health and wellbeing had been identified as an area of deterioration. As a consequence, the trust planned to strengthen the existing health and wellbeing services. The team offered a range of opportunities such as mental health first aiders, mindfulness, salary finance support, health checks and critical incidence stress management debriefs. The trust had procured a health and wellbeing mobile phone app and an absence management system to support staff and managers. The trust also looked to increase opportunities for flexible working and individual job crafting.

The trust had an equality and diversity strategy for 2016-20 with four goals: better health outcomes for all; improved patient access and experience; empowered, engaged and well supported staff; and inclusive leadership at all levels. Progress on the strategy was monitored in an annual inclusion and diversity monitoring report and equality delivery system self-assessment and action plan.

Staff Diversity

The trust provided the following breakdowns of medical and dental staff, nursing staff, and allied health professionals by ethnic group.

Ethnic group	Medical and dental staff (%)	Qualified nursing staff (%)	Qualified allied health professionals (%)
White	32.7%	94.4%	96.4%
Mixed	3.1%	0.2%	0.4%
Asian	47.6%	2.2%	1.3%
Black	2.9%	1.0%	0.4%
Chinese	2.0%	0.1%	0.2%
Other	7.8%	1.0%	0.8%
Unknown / Not stated	4.0%	1.3%	0.4%

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

Workforce race equality standard

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.

- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.

WRES Indicators from ESR (HR data) (*)	BME Staff	White Staff	Are there statistically significant difference between...	
			BME and White staff?	Last year and this year? (BME staff)
1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8a+	6.3%	3.1%	●	-0.9% ➡
1b. Proportion of non-clinical staff in senior roles, band 8+	2.4%	7.5%	●	0.3% ➡
2. Proportions of shortlisted candidates being appointed to positions	15.7%	23.8%	●	3.8% ➡
3. Proportion of staff entering formal disciplinary processes	0.7%	0.7%	●	-0.6% ➡

WRES Indicators from the NHS staff survey (**)		Proportion of respondents answering "Yes"			Are there significant differences between...		
		BME staff	White staff	All staff	BME and white staff?	This trust and its peer group?	Last year and this year? (BME)
5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Trust	34.6%	19.5%	23.1%	○	●	21.3% ○
	Peer group	*29.9%*	*27.9%*	*28.7%*			
6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	26.9%	27.8%	28.7%	○	●	-8.6% ○
	Peer group	*30.1%*	*26.0%*	*27.0%*			
7. Staff believing that the trust provides equal opportunities for career progression or promotion	Trust	85.0%	81.8%	82.4%	○	●	14.2% ○
	Peer group	*69.8%*	*86.3%*	*83.3%*			
8. Staff experiencing discrimination at work from a manager / team leader or other colleague?	Trust	11.5%	6.6%	7.0%	○	●	-7.8% ○
	Peer group	*15.9%*	*6.7%*	*8.5%*			

Trust staffing numbers (*)	2018		2017	
9. [BME Voting Board Members] and Board compared to overall staff demographic	[1]	●	[1]	●

Key

- ● Statistically significant or negative finding
- ● Not statistically significant
- ● Positive finding
- ○ Statistical analysis not undertaken as less than 30 BME staff responded
- ⬆ Statistically significant improvement
- ➡ No statistically significant change
- ⬇ Statistically significant deterioration

As of March 2018, one of the ESR staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

2. Proportions of shortlisted candidates being appointed to positions:

In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (15.7% of BME staff compared to 23.8% of White staff). This has increased by 3.8% compared to the previous year, 2017.

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), statistical analysis of the difference in score between White and BME staff was not undertaken as less than 30 BME staff responded.

There was one BME voting board member at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

Governance

There was an integrated governance structure with clear reporting lines to the board. Since the last inspection the trust board had moved from meeting monthly to every other month. The trust received reports from eight board committees: audit committee; community services committee, finance and performance committee; information management and technology committee; quality and safety committee; renumeration committee; secondary care transformation board and workforce committee. The community services committee was a time limited committee established to oversee the transfer of community services to the trust.

We reviewed a sample of recent board meeting papers and observed a board meeting during the inspection period. The public board meeting followed a standard agenda with a patient story, chair and chief executive reports, review of the board assurance framework, performance report and finance report. The public and private board had 'consent agenda' items which had been approved or reviewed at other committees to avoid repetition of discussion or decisions. We saw evidence of a proactive use of the board assurance framework and escalation of issues from the committees. At the board meeting we attended non-executive directors provided scrutiny, challenge and support to directors and the chief executive. Board members were respectful and appeared to be open and authentic.

All board committees were chaired by a non-executive director, with different membership and quoracy. Four non-executive directors were members of finance and performance committee, quality and safety committee and audit committee and three non-executives were members of the workforce committee. All executive directors were members of the quality and safety, finance and performance and workforce committees. Quality and safety and finance and performance committees met 11 times a year and audit and workforce committees met quarterly. The chair of each committee presented to the board, linked to the four strategic objectives (patients; people, performance; and partnerships) with the key areas that assurance had been gained or was required, although there was no written report from the chairs. Board committees received reports from a range of committees which reported to them. The committees were generally well attended by members and other staff.

Board committees used different formats for receiving information and escalating issues from their reporting committees. At the quality and safety committee chairs of reporting committees completed a standard template which detailed issues for escalation, top successes and risks as well as matters discussed. Audit committee, finance and performance committee and workforce committee received the full minutes of reporting committees. The quality and safety committee and the workforce committee had a standard agenda item for key successes, top risks and items for escalation from the meeting.

The trust had five divisions: medicine, surgery, specialist services; estates and facilities and community services. Each divisional had a management structure with a divisional triumvirate comprising of a divisional medical director, a divisional head of nursing and a divisional director of operations. Each division had a divisional quality executive group which met monthly and reviewed a divisional governance report, risks and reports from sub-specialty and divisional meetings. Different divisions had different meetings and groups although each had a group which reviewed and escalated risks. Divisional quality executive groups escalated key issues to the corporate quality executive group, with the chairs reports being consent agenda items at the quality and

safety committee. Divisions also had quarterly performance review meetings with all of the executive directors.

The corporate quality executive group met bi-monthly and had an agenda which discussed, reviewed and approved items which were cross-cutting across divisions. The committee discussed meetings with CQC, new policies and procedures, the ward accreditation schemes (ASPIRE), audits, leadership walkarounds and received reports from a range of committees.

The trust had a weekly executive scrutiny committee, chaired by the chief nurse or medical director which reviewed the serious incidents, complaints, new or settled claims and new or held inquests from the week.

Since joining the trust, the new chief executive had set up a leadership forum, which was a monthly meeting for cascading key messages and information to all managers across the trust, who would in turn share the messages with their teams. This was planned to replace the existing team brief to improve and update the communication of key information to staff.

In 2017-2018 the trust commissioned external consultants to carry out an independent review of the board and governance arrangements. This was followed up in early 2019 with a 'mini' review. Following the appointment of the new chief executive, the trust was about to start a governance review of the board and committee membership and structures. This would look at membership of committees as some leaders felt executive directors were over-represented as they all sat on the quality and safety, finance and performance, workforce and other key committees and meetings. Although there was a process to review the terms of reference for each of the committees annually there was no formal process to review the effectiveness of committees either at the meeting or annually.

The trust had a service level agreement with the local NHS mental health trust for the provision of psychiatric liaison services for patients attending or admitted to the hospital suffering from mental ill health. The two trusts had clear processes for the arrangements for mental health services at the trust and policies regarding confidentiality, information sharing and reporting and responding to safety concerns. The mental health liaison team had monthly meetings with trust staff which including reviewing incidents and the actions taken and learning.

The vertical integration of committees that focus on medicines optimisation was well established. The senior pharmacy teams of the trust and clinical commissioning group were represented on the trust's medicines management board to enable collaborative working, for example to reduce medicines errors when a patient transitioned between care services.

A large number of patient group directions were in use in different areas within the trust. The pharmacy service was leading on ensuring all patient group directions were up to date and operationally appropriate.

Management of risk, issues and performance

The trust had a board assurance framework which it used to assess the risks which could have an impact on the trust achieving its strategic objectives, the performance towards meeting the objectives and delivery confidence for each of the objectives. The board assurance framework was split between the four strategic objectives (patients; people, performance; and partnerships) and for each a RAG (red, amber, green) rating was given for delivery confidence and performance at every board meeting. Performance was based on a series of key measures which were weighted to give an overall score. Each objective was assigned to a reviewing committee and executive leads.

The board assurance framework was proactively used at the board and committees to assess areas of risk and performance and where assurance had been sought or was needed. At the board meeting we attended we saw discussions and escalations from the board committees focussed on the board assurance framework.

Board Assurance Framework

The trust provided their Board Assurance Framework, which details four strategic objectives within each and accompanying risks. A summary of these is below.

1. People: Every member of staff has the opportunity to achieve their purpose
2. Patients: Every patient received the best possible care
3. Partnerships: We work together for the best patient outcomes
4. Performance: We aim to be in the top 10%

(Source: Trust Board Assurance Framework – June 2019)

The finance and performance committee reviewed performance reports about unscheduled and planned care at every meeting, as well as performance measures in the integrated performance report. Divisional performance was monitored through quarterly performance reviews which included scrutiny of a range of governance, finance, performance and people measures. The reviews were attended by all executive directors. At divisional level the divisional quality executive committees monitored performance through monthly performance reports, divisional governance reports and performance dashboards. Divisions also presented to the finance and performance committee on a rolling basis on their financial position and performance.

The trust had performed well in recent years against nationally reported access to treatment standards. In 2018-19 the trust met the threshold of 92% for 18 weeks from the point of referral to treatment in aggregate patients on an incomplete pathway. The trust was ranked second in Greater Manchester, 13th in the Northern Region and 27th in the Country. The performance overall for all standards related to 62 day cancer waits in 2018-19 placed the trust first in Greater Manchester, fourth in the Northern Region and sixth in England. The trust was not meeting the standard to be treated in A&E within 4 hours. The performance had improved from the previous year, but was still not meeting the target. The trust was taking action to improve performance including redesigning parts of the service including the introduction of an urgent treatment centre and a community response team. In 2019 in the person led assessment of the care environment assessments the trust's overall score was 97.8% which was the third of all acute trusts in England.

Since the last inspection the trust launched an accreditation scheme (ASPIRE). Since starting in April 2018 the scheme had focussed on the accreditation of ward areas. The accreditation visit involved review and scrutiny of information, such as quality metrics, complaints and incidents and an inspection by assessors. Areas were awarded bronze for meeting the standards and silver if stretch targets were met. If areas did not achieve bronze they were given support to improve. At the time of the inspection 20 areas had been awarded bronze and three remained at white. The trust said that wards were encouraged to use quality improvement methodology to make improvements following visits. Progress of the scheme was tracked in a quarterly report shared at quality and safety committee. The trust planned to develop the scheme further by using it in other clinical areas and for community services.

Finances Overview

Financial metrics	Historical data		Projections	
	Previous Financial Year (2016/17)	Last Financial Year (2017/18)	This Financial Year (2018/19)	Next Financial Year (2019/20)
Income	£310m	£343.6m	£88.9m	n/a
Surplus (deficit)	£8.6m	£28m	(£5.4m)	n/a
Full Costs	£301.4m	£315.6m	£94.3m	n/a
Budget (or budget deficit)	(£688k)	£1.7m	(£5.8m)	n/a

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

The trust had demonstrated strong financial outcomes and performance over a number of years. The trust had delivered cash, capital and revenue plans in line with national requirements. In 2018-19 the trust met and exceeding its control total set at a deficit target of £6.4million before sustainability payments by NHS Improvement. The trust reported a year-end surplus of £3.8million, exceeding the control total by £10.1million. The trust received in-year provider sustainability funding (PSF) of £7.2million for meeting financial targets and the year-end position then triggered a series of further national and regional bonus payments, taking the final trading surplus figure to £28.0million.

During the year over £8million was invested in capital with particular emphasis on the upgrade to IT infrastructure in light of recent breaches to IT systems across the NHS. In 2019-20 the trust board was aware of risks around the delivery of the financial plan and was working on a recovery plan which incorporated internal and locality solutions.

We saw evidence that the trust had identified and was acting on risks which could affect the delivery of its financial plan. Following the transfer of community services to the trust on 1 April 2019 the trust had identified a much higher than predicted loss from the community services than identified externally through the due diligence exercise. The Trust was confident that within two years the synergies across services would negate the loss.

The trust was also affected by national concern that senior clinical staff would cease providing clinical sessions over and above their contract due to the impact on their personal finances caused by the tapering of their pension annual allowance. The trust had worked with clinicians, particularly within orthopaedics, which made up a higher volume of activity, to come to a solution to reduce the impact on activity and waiting times for patients.

The trust was also in the process of working with the local authority to develop an innovative community investment programme to create revenue and support long term funding in the local community.

National pressures had restricted the trust's capital programme in 2019-20 to £12million (its base plan had been £14million with a view to increase that amount if required). However, at the time of the inspection the trust was planning to extend the programme. The trust had developed plans to open an inpatient community assessment unit in 2020 and investing £2.5million on medical equipment including a replacement MRI scanner.

Since the last inspection the trust had refreshed its cost improvement programme strategy, which was now known as the service and value improvement (SAVI) programme. In 2018-19 the trust achieved £12.7million of savings of which £7.4million were recurrent. In 2019-2020 the trust

planned to achieve savings of £14.5million from service and value improvements. Service and value improvements were made up of large-scale, complex and strategic programmes and programmes managed within the divisions. Oversight of service and value improvement programmes was monitored through a programme board and finance and performance committee. Details of schemes and progress could be monitored on an app that had been developed.

A quarterly "Safe, Effective, Caring" report was submitted to the quality and safety committee, the private part of the trust board and the clinical commissioning group, which reviewed a number of metrics aligned to the Care Quality Commission key lines of enquiry of safe, effective and caring. The report triangulated concerns and issues from different sources and data.

The trust had a systemic programme of clinical and internal audit to monitor quality and processes. Board members used a risk-based approach to plan the annual internal audit plan with the internal auditors. The audit committee had oversight of the audit plan, tracking the implementation of recommendations from audit. The audit committee reviewed the audit plan throughout the year and where necessary added and re-prioritised audits if risk emerged or where re-audit was required. The chair of the audit committee gave an example of a re-audit added to the plan in year following limited assurance from an audit of pharmacy stocks. The overall opinion from the head of internal audit for 2018-19 was substantial assurance that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently. This was an improvement from 2017-18 when moderate assurance was given.

The trust had an annual clinical audit programme which incorporated national patient outcome audits, national audits for inclusion in the Quality Accounts and corporate clinical audits and priority audits identified by the divisions. The plan was approved by the clinical audit and effectiveness committee and reviewed by the audit committee.

The trust actively benchmarked its performance against other trusts within the region, using a number of measures including performance information, national patient surveys, friends and family test, data from Dr Foster, patient reported outcome measures and the safety thermometer. The trust chose 11 key measures which it benchmarked itself to see where it ranked and whether it was within the top 10% of trusts. This was reported to the board in the integrated performance report.

The trust had a comprehensive process to identify, understand, monitor and address current and future risks. The approach to managing risk was set out in the trust's risk management strategy. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks were assigned a current, initial and target rating with control and actions recorded. Risks were recorded on local, divisional or corporate risk registers depending on the current rating. If a risk scored lower than eight it was recorded on the local risk register, if it scored between nine and 12 it was recorded on the divisional risk register and if it was 12 and above on the corporate risk register. In addition to risks which were escalated due to the scoring, the risk had developed a process for managing 'pipeline' risks, emergent or potential future risks, this helped identify and act on risks before they escalated.

Each division had a committee or meeting which was responsible for approving risks at divisional level. The trust had a committee (risk environmental management committee) to review all of the risks on the corporate risk register and pipeline risks to calibrate the scoring, recommend action and identify potential risks. Risks on the corporate risk register were assigned to a relevant board committee and linked to one of the four objectives (patients, people, performance, partnerships).

The trust maintained a corporate risk monitoring tool which had a tracker of the risk scores over a 22 month period so changes to risk scores could be monitored.

In the papers we reviewed we saw evidence of risks being escalated through the divisional committees, the risk environmental management committee, the board committees and to the board. During the board meeting we attended we saw an example of an exceptional risk which had emerged around the availability of syringe drivers, which had been escalated directly to the board due to the scoring of 25.

While the corporate risk register reflected the risks understood and articulated by leaders, during the core service inspection we had identified issues which had not been identified and acted upon timely. For example, some of the environmental risks at Wrightington Hospital had only been entered into the risk management system shortly before the inspection, despite being ongoing and other environmental risks at Leigh Infirmary were not on risk registers. The trust said that it was currently auditing divisional risks to ensure they were completed in line with the policy. As part of the governance review the trust would be looking at the risk management processes, looking at how risks were managed between committees. It also planned to look at developing work on risk appetite, which leaders told us was currently looked at on an issue by issue basis.

Trust corporate risk register

The trust provided a document detailing their highest profile risks. There were 16 risks which had a score of 20 which was the highest score as at June 2019.

Date risk opened	ID	Description
February 2018	1989 (Infection Control)	There is a risk that patients with infectious conditions may not be able to be appropriately isolated in a timely manner due to a lack of side rooms
July 2017	S ICU 014	Risk of injury/equipment failure/fire caused by failure of ceiling pendants in ICU/HDU as a result of excessive weight beyond safe
October 2018	S DEL 019	Only one Maternity theatre being available for elective and emergency cases
November 2018	SSCS812	Upgrade of the PAS>Somerset Cancer Registry interface which is currently causing extra workload and mass duplication and has the potential to delay a suspected Cancer patients diagnostic and treatment pathway.
March 2018	1994 (GOV)	There is a concern that patient care may be compromised and length of stay increased as a consequence of patients not being admitted to the right ward when admission to hospital is required due to bed blockages within the Trust.
December 2018	2261 (GOV)	Failure to identify the root cause and to learn lessons following the Trust's never events reported during 2017-18 and 2018-19 could result in further never events causing serious harm to patients, increased scrutiny from regulatory bodies and increased reputational risk.
February 2019	Med 2551	There is a risk to patient safety due to a lack of medical beds resulting in patients being harmed.
August 2018	Med Risk 2525	The provision of a 7 day pharmacy service across the RAEI and Wrightington sites – currently compromised

August 2018	(IM&T) 2029	There is a concern that backend Infrastructure fails or becomes vulnerable because of end of life resulting in no access of IT systems to staff resulting in risk to both patient care and Trust reputation.
December 2017	HR84	Ability to recruit and retain to required staffing levels for service delivery & service development plans
April 2018	S DIV 032	There is a concern that the current arrangements for the storage of medical records are inadequate. This is due to inefficiencies in the storage, handling, security and timely delivery of records at the point of need, combined with the embargo on destruction of records since July 2015 due to the Independent Inquiry into Child Sex Abuse.
May 2017	2424 (Patient Safety)	Medical Device training records are inaccurate and unreliable due to the lack of an effective centralised database.
July 2018	HR93	Breaching the NHSI Agency ceiling
May 2017	Med 2451	Dietetics Staffing Levels
April 2018	Med 2495	Lack of Respiratory Consultant
November 2016	S RAIN 013	Lack of Tier 4 beds for CAMHS patients

(Source: Trust Corporate Risk Register)

On 1 April 2019 the trust acquired a full range of community services from the local community health trust. The trust had instructed a leading accountancy firm to complete the due diligence ahead of the transaction, following the initial proposals in autumn 2018. The trust had formed a community services committee to increase the oversight of the transition of services and had escalated risks to the corporate risk register. The trust had acted to mitigate known risks such as issues with IT interoperability and changes of policies and procedures, and also identified and acted on unknown risks such as significant staffing vacancies. The trust had commissioned an internal audit of the transaction, which was taking place at the time of the inspection. The trust was also reviewing the leadership and divisional structure of the community division to ensure it was appropriate for the service.

For a number of years mortality indicators (summary hospital-level mortality indicator and hospital standardised mortality rate) had indicated that the trust had a higher than expected number of deaths. This had been an issue when we last inspected the trust in 2017. The hospital standardised mortality rate for the trust had improved and the hospital-level mortality indicator had improved but the trust was still flagging on the indicator as a trust with a higher than expected number of deaths. The trust had an improvement plan and had a mortality group, chaired by the medical director, which was set up in June 2017 and reported to the quality and safety committee. Quarterly mortality reports were also shared at the trust board as part of the learning from death process. The group carried out deep dives on conditions and pathways as well as the weekly review of deaths with a focus on conditions with excess deaths. The trust had invited external stakeholders to present including the clinical commissioning group, Dr Foster, Advancing Quality Alliance and the internal auditors. The trust had also invited medical directors from other Manchester trusts to share good practice. Mortality performance indicators formed part of the integrated performance report and weighted board assurance framework. The incoming chief executive articulated that this would be priority for him for the trust to have a refreshed focus on.

In 2018-19 the trust reported five never events with a further three never events in 2019-2020. The trust had asked NHS Improvement to carry out a review of all of the never events in addition to its investigation of each through the serious incident process. Since the never events, the trust had

focussed on ensuring that National Safety Standards for Invasive Procedures (NatSSIPs) were being followed and appropriate Local Safety Standards for Invasive Procedures (LocSSIPs) were in place in every area and team where invasive procedures take place. The trust had also recently run human factors training for nearly 60 staff, of which 80% were medical staff/surgeons.

Staffing continued to be a risk for the organisation and was reflected in the board assurance framework and some of the high risks on the corporate risk register. Staffing risks were monitored through the workforce committee and safe staffing reports were received by the quality and safety committee and board, which triangulated with quality and safety measures. The trust was exploring different ways to recruit and retain staff. The trust had been involved in the national pilot for the training of nursing associates and was offering increased flexibility around work patterns, opportunities to move around areas, incentive schemes, financial rewards in areas which were harder to recruit and exploring new staffing models. The plans for the new community assessment units, which would be opened in Autumn 2020, were to have a mixed workforce made up of nursing, allied health professions, pharmacy staff and GP input rather than more traditionally consultant led staffing structures.

A key area on the risk register in relation to medicines was the high number of incidents involving discharge medicines, including their supply after the patient has left the hospital. This was an area that required further action to address.

The trust had a process to review the impact of developments to services or efficiency changes on quality and safety. For every saving and value improvement programme a quality impact assessment was completed. The quality improvement assessment and mitigations were signed off by the chief nurse and medical director. The quality impact assessment sought assurance the impact on patient safety, clinical effectiveness and patient experience.

Information management

The trust had an integrated performance report which was reviewed at the trust board and board committees. The performance report had a mix of measures covering quality, operational performance and people's views. The performance report had a mix of measures about harm free care, mortality, maternity, patient experience, workforce and nationally reported performance. The report included maternity and mortality which had been identified as areas of risk to the trust due to the previous CQC inspection and mortality indicators. Measures in the integrated performance report were RAG rated (red, amber, green) against targets. For each measure the monthly and year to date position were recorded in addition to a trendline mapping performance over a 13 month period. This enabled the board to measure improvement in addition to gaining assurance. Since the last inspection the report had been revised following feedback from non-executive directors with some metrics in relation to performance being removed so the report had more of a focus on quality. Supplementary reports on unscheduled and planned performance had been created to ensure coverage of detailed performance metrics at the finance and performance committee.

The finance report was reported separately from the integrated performance report and in the public board meeting included basic in month and year to date coverage of income and expenditure, balance sheet and capital spend. The finance report for the private board meeting included more detailed financial reporting including more granular information, commercially sensitive information and analysis of the financial position.

A quarterly assurance medicines report was provided to the quality and safety committee.

Nurse and clinical support worker staffing was reported to the board in the mandated safe staffing report. The report included fill rates and care hours per person per day. The report triangulated with measures of harm (for example, falls, pressure ulcers and drug administration errors), staffing measures (sickness and vacancies) and the real time patient experience survey. This meant the board could identify if staffing pressures had had an impact on patient safety or experience.

The trust had processes and a data quality team to ensure information was accurate, timely, valid and reliable. The trust had a data quality policy which outlined staff roles and responsibilities and a data quality team which worked with divisional teams to advise on correct recording practices. There were routine processes in place across the data quality team and business intelligence team to validate NHS Numbers, check new patient registrations to remove duplicates, resolve clinical commissioning group challenges and report on incomplete data. The trust had a data quality dashboard which was used by the divisional teams to validate their data quality issues and performance each month. The trust also had developed a data quality app to monitor and resolve data quality issues.

The trust had a data quality committee which had oversight of data quality with an annual work plan which included data quality, clinical coding and information governance reviews. Data quality audits were measured against the trust's data quality kite mark and rating applied against the source, timeliness, accuracy and validation.

Information technology at the trust had a high profile with the information management and technology committee reporting directly to the board. The trust had a digital strategy and plans to develop the use of technology further, for example with the use of video consultations and virtual clinics. The trust was one of only six organisations in the North West accredited at level two for excellence in informatics which is externally assessed by the North West Informatics Staff Development Network.

The trust had implemented an electronic patient record system between 2016 and 2018 which was now used in most clinical area, with some exceptions such as maternity. The system had enabled the trust to improve the monitoring of clinical performance as it gave access to live information about patient care. The trust had been chosen by the electronic patient record supplier to be their 'reference site' for Europe, Middle East and Africa. The electronic patient record provider had recently opened an experience centre on the Royal Albert Edward Infirmary site which the trust would be able to use to develop digital healthcare delivery. The trust was also looking to partner with other hospitals using the system globally to share learning. The trust continued to develop the system's scope and increase its effectiveness. The trust reported that the next stages for development included implementing condition specific solutions to assist in improving outcomes for sepsis, liver disease, pneumonia and acute kidney injury.

The trust had developed more than forty apps to support staff in viewing live data in graphical formats to improve quality, performance and sustainability. Some of the apps included an A&E app, hospital flow, theatres as well as apps developed for corporate functions such as procurement and finance. The apps could be accessed by staff remotely and on mobile telephones.

One of the apps developed since the last inspection was a ward app which included quality and performance indicators at ward or department level. The app shows quality metrics aligned to CQC's five domains with a range of metrics including length of stay, discharges, complaints, incidents, staffing red flags, readmissions, occupancy and patient survey results. The data could be aggregated to ward, department, division or site and had been used by the trust for CQC self-

assessments and internal inspections, ward accreditation visits and to inform walkabouts. The trust had also developed a ward tracker demonstrating the ASPIRE achievement level and other intelligence held at ward level which included the CQC self-assessments.

The trust had systems and processes to protect the trust from cyber-attacks, such as the Wannacry attack that affected the NHS in 2017. The attack had very limited impact on the trust, but following the attack the trust carried out a deep dive and put in place actions to strengthen the cyber security. The trust had since had an external audit to validate the security systems at the trust. The trust had its own accredited data centre facility, which it leased space from to other organisations.

Since the last inspection the trust had started using an electronic system to manage the maintenance and servicing of equipment. Equipment was barcoded and entered on a system so scheduling of inspection, service and calibration could be monitored centrally.

The trust had arrangements to ensure that data or notifications were submitted to external bodies as required. Incidents, including serious incidents, were reported as required to the NHS national reporting and learning system or the NHS strategic executive information system. Incidents which needed to be reported were reviewed by the executive scrutiny committee to ensure that reportable incidents were identified.

The trust had arrangements to ensure the integrity, availability and confidentiality of information and patient records. The trust displayed information for the public about information governance and how to access records clearly on the website. The trust completed the data security and protection toolkit in 2019-20 and assessed itself as having met the ten data security standards. The trust had reported a serious incident which related to a data security breach in September 2019. This related to staff accessing the records of 1,735 members of the public. The trust had reported the incident to the Information Commissioner's Office, put in place actions including writing to those affected and all staff. The trust had also purchased new software and shared the outcome with other organisations. As a consequence of the incident the trust had also raised the risk rating on the corporate risk of records of the electronic patient record system being accessed from 16 to 20.

Engagement

The trust listened to the views of patients and the public to shape and develop services at the trust. The trust had a patient and public involvement strategy for 2019-2022 which set out the trust's aspirations for developing patient and public involvement at the trust with a supporting action plan. Progress of the strategy was reported quarterly to the engagement committee and quality and safety committee and twice yearly to the board.

The trust had recently revised the structure of the patient and public engagement committee which was previously chaired by the lead governor. This was now chaired by the governance director with the governors forming a separate committee which would have a focus on the trust membership. The patient and public involvement function sat within the company secretary's portfolio, although had informal links with the chief nurse and complaints team. Patient experience and public involvement did not report into the board committees and we were told by some staff that it had less prominence at the trust and was not always a priority for divisional staff. We were told that the governance of patient and public involvement would be reviewed as part of the forthcoming governance review.

The trust used a range of sources to gather and act on the views of patients and members of the public. The patient and public involvement team led the real time patient surveys which asked 13 questions to patients each month with the dashboard being reported to the board. We were given examples of actions taken in response to reduced ratings about whether patients knew their consultant. This included moveable 'Hello my name is' boards so patients in beds could see the name of the consultant. The trust also carried out always events surveys undertaken by clinical lay auditors, who were trained volunteers, to check if always events were being carried out.

The trust also used friends and family test data, comment cards and information from national surveys (inpatient, maternity, children and young people and urgent and emergency care) to inform changes and improvements. The trust gave examples of changes made as a result of the inpatient survey such as discharge wallets to improve the discharge process. Since the last inspection the trust had set up a "matron's helpline for patients, carers or family to a matron if they needed assistance and did not wish to speak to ward staff. Patient surveys were used to identify areas for improvement with medicines, for example counselling patients about their medicines, including side effects.

Public and patient views were engaged and involved in decision making at the trust. The trust actively used experience based design principles in the planning and development of new and existing services. Experience based design is where patients and staff come together to look at the patient journey, experience and clinical pathway, focussing on what is good about the journey and also what was negative and what gold standard would look like. The trust had hosted an experience based design event for patients and carers to assist with the redesign of the neonatal service. Neonatal parents spoke about their experience, drawing out the positive and the negative elements of their care with a view to bringing changes that will lead to the establishment of a gold standard patient experience.

Patients, the public and other stakeholders were consulted with the publication of new strategies. The public had been consulted on the updated trust strategy, which was paused, and would be consulted before the strategy was published in 2020. The trust had an extensive panel of more than 600 readers to proof read any leaflets or information before it was published.

The trust actively engaged with people from a range of equality groups and hard to reach groups. Within the last year the trust had visited local community groups such as a blind group to ask about experiences of attending hospitals and a deaf group which had led to the implementation of pagers in the emergency department. The trust had engaged with a learning disability group to arrange familiarisation visits and tours of areas such as the emergency department for patients with a learning disability. The trust had met with the community at a local mosque and attended the Wigan Pride event to ask for feedback from LGBTQ+ community. In the last year the trust had undertaken a patient experience survey for Black and Minority Ethnic cancer patients.

We were told that the community services which the trust had acquired on 1 April 2019 had very little public engagement currently and this had already been an area of focus. A survey had been sent to 1,000 patients who used treatment rooms or had home visits which had led to actions to improve clinic times and locations. The trust had plans for a walk in centre survey in January 2020.

All services and policies at the trust were equality impact assessed to ensure all protected characteristics were reviewed and any positive or negative impacts identified. The trust had a transgender patient guidance for staff policy which was used to ensure privacy and dignity of patients was maintained and to ensure that care was delivered in a patient centric compassionate manner.

The trust had an active and enthusiastic group of 28 governors made up of members of the public, members of staff and representatives from public organisations or NHS partners. The council of governors met four times a year and was attended by the non-executive directors. The council of governors had specific duties including appointing a chair and non-executives and receiving and approving the annual report and accounts. Governors were involved in the organisation and oversight of the trust in addition to hospital patient surveys, walk rounds and events for trust members and the public. Governors sat on some of the committees at the trust such as the serious incidents requiring investigation panel and the quality and safety committee. Governors told us they received very good and timely information and they had strong relationships with the non-executive directors. The governors had been actively involved in the recent recruitment exercises for the chief nurse and chief executive.

As a foundation trust the public and staff can become members of the trust to influence decisions and become elected to the council of governors. The trust had more than 10,000 members. The trust sent a newsletter to members with information about the council of governors, trust initiatives, awards and events. The trust also arranged regular events for members which focussed on topical areas or priorities.

The trust had more than 300 volunteers. Volunteers worked in a range of roles across the hospital. The trust had ambitions to increase the number of volunteers, particularly of a working age, and their activities at the trust. In 2018 the volunteers at the trust won the Queen's award for voluntary service. The trust also had lay representatives on a number of committees to give the patients perspective including divisional quality executive committees, quality champion committee and discharge improvement committee.

The trust actively engaged with staff so their views were reflected in the planning and delivery of services. The trust used a range of methods such as listening events and graffiti boards as well as surveys and its own engagement tool. The trust also had a weekly newsletter for staff and quarterly magazine.

The trust used the annual NHS staff survey and an award winning engagement tool it had developed (Go Engage), which included quarterly pulse surveys, to improve staff engagement and culture. Every quarter the trust sent pulse surveys to every member of staff which could be broken down into divisions, departments or teams. The trust used the engagement tool it had developed to benchmark the results and collaborate with other NHS trusts who were using the tool. The tool surveys staff and statistically analyses data for trends and hot spots. The trust had identified areas for focus in the nine enablers of engagement set out in Go Engage (influence, clarity, work relationships, perceived fairness, recognition, personal development, mindset, resources and trust) and put in specific actions to improve engagement in those areas. As well as organisational level work the Go Engage model included local interventions through the staff engagement pioneer programme which included team diagnostic and team based actions.

The trust had an annual recognising excellence awards to celebrate excellence by individuals and teams. The trust had an awards ceremony event to celebrate the nominees and winners. In 2019 the trust presented awards for: best example of support services; Go Engage award; hidden gem; care and compassion; innovation and improvement; working together; learner of the year; and chairman's award. The trust also awarded "Going the Extra Mile" cards to staff in recognition of their work.

The trust reported a very positive relationship with both the clinical commissioning group and local authority and were actively involved in the Healthier Wigan partnership discussions. The trust reported that it was completely aligned with regard to managing care closer to the home of the

patient. The trust also said it had active engagement with the council about issues such as strategic estates planning and workforce.

The trust was an active member of the Greater Manchester Health and Social Care partnership specifically in relation to acute service transformation. The trust was the service transformation leads for both MSK orthopaedics and cardiology.

The trust had strong links with two neighbouring NHS trusts who collectively made up the North West Sector within the Greater Manchester. The trust had an existing shared service board with one of the trusts for the delivery of pathology and decontamination services and was working with the other trust about sharing the delivery of clinical pathways. The trust also had strong links with the local specialist cancer NHS trust with arrangements for the specialist trust to deliver outpatients, diagnostics and chemotherapy from the Royal Albert Edward Infirmary site.

The trust worked well with the local mental health trust which provided psychiatric liaison services from the Royal Albert Edward Infirmary site. The mental health trust supported the trust by providing training in mental health and advice at all times. Staff from the mental health trust told us the relationships throughout the trust were very good, and the safeguarding team relationship was especially effective.

Learning, continuous improvement and innovation

The trust had a well-established and embedded focus on quality improvement. The trust had a quality improvement strategy and systemic approach to quality improvement using the Institute for Healthcare Improvement Model for Improvement. Since the last inspection the trust had developed a quality improvement tool which could be used at local team level, MyQ. The trust described MyQ an intervention at local team level seeing the use of improvement boards and improvement huddles on wards and departments, empowering staff to identify and then address issues to make improvements.

Since 2012 the trust had been running a quality champion programme which was the flagship programme to promote and implement quality improvement. The programme was open to all staff irrespective of role or grade. Quality champions worked on projects to improve quality and efficient. In 2018-19 three quality champions training programmes took place which included modules on measurement, data collection and PDSA (plan, do, study, act), as well as sessions on resilience, human factors and leadership. The trust had a quality champions committee which monitored and supported the progress of the projects.

Since 2012 the trust had trained 400 quality champions. Quality champions were awarded bronze, silver and gold status. Bronze for completing the training; silver for demonstrable and sustainable improvement over three months and gold for large scale improvements which have been shared beyond the trust. In 2018-19 there were 8 silver and 5 gold awards given. Since the end of 2018 the trust had formed a transformation team, made up of Quality Champion staff and the project management office to align the work around the service and value improvement programme and quality improvement projects.

The trust held an annual quality champion conference where exemplar quality champion projects are presented. At the conference in October 2019 projects presented included a project in the urgent and emergency department ‘Sensible Test Ordering Practice’, the development of a critical care patient acuity and staffing risk assessment, an 18 week tracker, improving pregnancy loss care and the day case total hip replacement pilot.

The trust shared learning with other NHS trusts as part of the NHS Quest network, a member-convened network of 16 NHS trusts who worked together to improve safety and quality and lead the way in technology enabled innovation. As part of NHS Quest the trust was involved in programmes which included experience days (visits to other member trusts), improvement science for leaders, improving system flow, theatre safety culture and employment improvement. The trust was also a member of Advancing Quality Network (AQUA) a North West based NHS health and care quality improvement organisation involved in transforming the safety and quality of healthcare.

The trust had increased its participation and recruitment of patients for research studies since the last inspection. The trust had a research strategy which aimed to include all clinical staff in research. In 2018-19 the trust recruited 2,356 patients to be participate in research approved by a research ethics committee, this was above the target agreed with the National Institute for Health Research (NIHR) of 1,032 and significantly higher than the 2017-18 when 884 patients were recruited. In the same period the trust participated in 104 NIHR portfolio clinical research studies and 28 non portfolio studies, also an increase on the previous year. These were in a wide range of specialities.

In 2018-19 the trust was recognised for its research at the Greater Manchester Clinical Research Awards where the cancer team won outstanding contribution for their oncology collaboration with a regional cancer specialist trust and a senior research nurse was runner up in research nurse of the year.

The trust had expanded seven-day pharmacy service to Wrightington Hospital which had provided patients at this location with a better medicines optimisation service. Antibiotic usage was audited regularly. Instances of non- compliance with policy were fed back to the teams involved and across the division to enhance learning.

The trust had plans to become a teaching hospital trust and strengthen existing links with a local university. The trust had a positive relationship with the university and in the last year had appointed a non-executive from the university, with further plans to appoint a governor from the university. The main collaboration was the trust hosting a programme for doctors from overseas to work in the NHS in Greater Manchester. Doctors on the ‘earn, learn and return’ programme worked in the UK while gaining experience and a master of surgery or masters in medicine qualification from the university to take back home. This programme had rapidly developed and the trust recruited around 150 students to the programme in Sept 2019. The trust also was looking at delivering a similar programme for nursing staff and the proposed development of a school of nursing when the university opened a new research and education centre in Wigan in Sept 2021.

The trust was in the process of developing an agreement with a pharmaceuticals company for a national research facility for orthopaedics at the Wrightington Hospital site. The agreement would lead to significant investment in the trust and a co-located research facility.

The trust had a number of external reviews of services within the last year including a requested review of the never events by NHS Improvement and a requested external review of ophthalmology services by the Royal College of Ophthalmologists following a serious incident. The trust had also had visits and inspections by other statutory bodies such as the Human Tissues Authority. The trust had completed self-assessments against the Gosport War Memorial Hospital independent panel report.

The trust had processes to investigate, monitor and share learning from serious incidents. Any incident identified as causing moderate or above harm to a patient was escalated at a daily teleconference and rapid review (72 hour review) investigations were commissioned. Incidents

were reviewed weekly at the executive scrutiny committee to identify whether they met the threshold for a serious incident (StEIS) and would require a full root cause analysis investigation. Outcomes of investigations were reviewed by the serious incident requiring investigation panel which would also monitor completion of actions plans. The trust said that no action plan was signed off until adequate assurance had been provided and agreed by the committee. The commissioners also reviewed incidents through their monthly serious incident and never event panel and bi-monthly quality, safety, safeguarding group. Lessons learned from incidents, complaints, claims and inquests was a standard agenda item at the executive scrutiny committee. A record of new serious incidents and summary of themes and learning was considered by the quality and safety committee and was part of the consent agenda at the private board meeting.

Since the last inspection the trust had worked on increasing family involvement in serious incidents although acknowledged that it was still sometimes a challenge. Where serious incidents involved a death, the trust would assign a bereavement nurse as the single point of contact. Since coming into post the new chief nurse reviewed all serious incident investigations and the trust were planning to explore a more structured approach to serious incidents relating to pressure ulcers.

The trust's serious incident processes supported the oversight and escalation of safeguarding concerns and issues which related to serious incidents, through review at the executive scrutiny committee and involvement of members of the safeguarding team. During the inspection we reviewed a sample of serious incidents and found reports were generally well written with a comprehensive description of events. When learning had been identified there were comprehensive actions plans. We saw evidence of multidisciplinary input to investigations. The template used by the trust did not have opportunities to identify use of root cause methodologies such as fishbone or 'five whys'.

The trust was proactive at developing income from non-clinical services which it provided to other organisations. The trust had developed its Go Engage engagement tool which it had sold to other health organisations, had a joint arrangement with two trusts to provide occupational health services and had developed its catering services, which were accredited to supply and distribute food to other organisations. The trust was also looking at opportunities to develop the programme for doctors from aboard as a national venture.

In 2018 the trust was the first in the country to set up an independent domestic violence adviser service. In its first year the service received 362 referrals. Of the referrals 21% were male victims who had not disclosed to any other service and 5% were staff members. The trust reported there had been a notable number of older patients who had disclosed whilst an inpatient and a rising number of sexual abuse referrals. The service had won a national nursing newspaper award and the success of the service had been shared with other organisations, including NHS England.

The trust had a process for identify, reviewing and sharing learning from deaths which occurred at the trust or to patients who had been at the trust. This was in line with the NHS National Quality Board guidance on Learning from Deaths published in March 2017. This built on a process which had been used by the trust for around ten years. The trust had criteria for the deaths which would be reviewed (excluding certain deaths, for example patients receiving end of life care). Deaths were reviewed weekly using a structured judgement process and a summary of the reviews and learning was shared weekly to a wide range of clinical staff across the trust. Where concerns were raised about the death these would be escalated to the medical director, chief nurse and governance director and reviewed at the weekly executive scrutiny committee and where appropriate duty of candour applied. The trust would then follow the serious incident process. Deaths were also reviewed locally at mortality and morbidity review meetings. Quarterly mortality

reports were submitted to the board and updates from the mortality review were presented at the mortality group. We reviewed a sample of death reviews during our inspection and found that the trust has a clear process for identifying and reviewing deaths and sharing learning to staff.

The trust reported that in 2018-19 some of the learning from deaths it had identified included concerns in relation to tracheotomy care and cannulation. The trust noted that it had experienced pressures which had led to patients being admitted to wards that were not the most appropriate to the care and treatment that they needed. There had been instances of late delayed diagnosis of thoracic aortic aneurism and instances of poor sepsis care in relation to antibiotics. The trust had taken actions including established a group to review tracheostomy care and the introduction of a vascular access specialist nurse role. The trust used its 'right patient right ward' group to improve the appropriateness of wards for patients. The trust had made changes to the patient pathway to facilitate an earlier diagnosis of thoracic aortic aneurism and had taken actions to improve sepsis care.

The trust had plans to introduce the medical examiner role with the board approving the business case with plans for the role to start in April 2020.

All complaints and concerns were reviewed weekly by the executive scrutiny committee. The more complex and serious complaints were reviewed and discussed in detail to ensure that a prompt decision was made regarding the progression of these complaints and, where appropriate, instigation of a concise or comprehensive investigation. The trust had different response times for different grades of complaint (30 days; 40 days; 60 days; 60+ days depending on the grade). The trust reported compliance with those timescales agreed with the complainant in the trust performance report. At the time of the inspection the trust was reporting that the agreed target was met in 64.6% of complaints, although the trust reported that contact was maintained during the process until the response was sent. The trust had put in place an improvement plan which had been escalated to the quality and safety committee to improve performance with the completion of complaint responses.

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Current performance
What is your internal target for responding to complaints?	3	100%
What is your target for completing a complaint	30, 40 or 60 days	80% and as at 29/7/2019 60% accumulatively
If you have a slightly longer target for complex complaints please indicate what that is here	60+ days	100%
Number of complaints resolved without formal process in the last 12 months?	665 (July 2018 – June 2019)	

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Number of complaints made to the trust

From July 2018 to June 2019, the trust received a total of 523 complaints. The highest number of

complaints were for medicine, with 27.7% of total complaints, followed by surgery (22.6% of complaints) and outpatients (16.3%).

Core Service	Number of complaints	Percentage of total
Medicine	145	27.7%
Surgery	118	22.6%
Outpatients	85	16.3%
Urgent & emergency care	62	11.9%
Trust wide	26	5.0%
Other	23	4.4%
CYP	18	3.4%
Maternity	15	2.9%
Community*	9	1.7%
Diagnostics	9	1.7%
Gynaecology	5	1.0%
Private patients	4	0.8%
Critical care	2	0.4%
EoLC	2	0.4%

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Compliments

From July 2018 to June 2019, the trust received a total of 3,117 compliments. The highest number of compliments were for medicine, with 50.3% of total compliments, followed by surgery (13.3% of compliments).

A breakdown by core service can be seen in the table below:

Core service	Number of compliments	Percentage of total
Medicine	1,567	50.3%
Surgery	416	13.3%
Outpatients	348	11.2%
Critical Care	255	8.2%
Maternity	222	7.1%
CYP	130	4.2%
Urgent & emergency care	112	3.6%
EoLC	55	1.8%
Community	12	0.4%

(Source: Routine Provider Information Request (RPIR) – Compliments)

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust's services have been awarded an accreditation.

Accreditation scheme name	Service accredited
Joint Advisory Group on Endoscopy (JAG)	Endoscopy Unit Leigh
Macmillan Quality Environment Award (MQEM)	Achieved for TLC and Cancer Care Centre June 2017

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).

The trust's finance team won the Chartered Institute of Public Finance and Accountancy health team of the year in 2018 and the procurement team were rated number one in the Department of Health's procurement league table. The trust had won national awards for Go Engage and the independent domestic violence service and one of the trust's nurses won a national nursing award for innovative work on early diagnosis of pancreatic and biliary cancers.

Royal Albert Edward Infirmary

Surgery

Facts and data about this service

Surgical services at Wrightington, Wigan and Leigh NHS Foundation trust are provided across three main hospital sites:

- **Royal Albert Edward Infirmary (RAEI)** for elective, emergency and day case surgery.
- **Leigh Infirmary** for day case surgery for clinically suitable patients.
- **Wrightington Hospital** for the majority of elective orthopaedic surgery.

Surgical patients are admitted for a wide range of procedures in the specialities of colorectal surgery, ENT, breast surgery, general surgery, gynaecology, ophthalmology, maxillo facial surgery, urology and vascular surgery.

The urology department offered a range of services for patients including rapid access clinics, prostate assessment, vasectomy, haematuria, one stop and out of hours evening clinics.

Trauma patients and those that required post-operative HDU support following elective surgery were accommodated in the theatres on the acute RAEI site.

(Source: RPIR – Acute context tab)

The trust had 32,554 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 8,180, 17,595 were day case, and the remaining 6,720 were elective.

(Source: Hospital Episode Statistics)

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. The inspection took place on 22 to 24 October 2019 and we visited a number of areas across the surgery core service including Theatres, Aspull, Swinley, Orrell and Langtree wards, the maxillo facial surgery department, surgical admissions unit, day case recovery and the preoperative assessment unit.

During our inspection we spoke with 65 members of staff from various roles including allied health professionals, matrons, medical staff, clinical directors, divisional business leads, nursing and support staff, ward managers and theatre co-ordinators.

We reviewed 20 patients records and 21 prescription charts.

We observed care and treatment and interactions between staff and patients and those close to them Across the areas we visited. To identify the experience of patients and those using the services we spoke with nine patients and two patients relatives.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff. Nursing staff compliance with mandatory training was close to the trusts target. However, compliance for medical staff was low against the trusts target.

Mandatory training completion rates

The trust set a target of 95% for the completion of mandatory training. The tables below detail the mandatory training modules which staff are required to cover and provide a compliance percentage for each module.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified nursing staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-Fraud Awareness	432	455	94.9%	95%	No
Blood Collection	399	455	87.7%	95%	No
Blood Transfusion	388	455	85.3%	95%	No
Bowel Management Programme	435	455	95.6%	95%	Yes
Conflict Resolution	431	455	94.7%	95%	No
Delirium	179	455	39.3%	95%	No
Dementia Training	435	455	95.6%	95%	Yes
Emergency Planning	433	455	95.2%	95%	Yes
Equality and Diversity	431	455	94.7%	95%	No
Fire Safety	442	455	97.1%	95%	Yes
Health and Safety	431	455	94.7%	95%	No
Infection Prevention		455	0.0%	95%	No
Information Governance Clinical	435	455	95.6%	95%	Yes
Medical Devices	435	455	95.6%	95%	Yes
Medicine Safety	436	455	95.8%	95%	Yes
Moving and Handling Clinical	431	455	94.7%	95%	No
Resuscitation	436	455	95.8%	95%	Yes
Safe Use of Insulin	397	455	87.3%	95%	No
Slips Trips and Falls Clinical	430	455	94.5%	95%	No

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at

trust level for medical staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-Fraud Awareness	115	159	72.3%	95%	No
Blood Collection	114	159	71.7%	95%	No
Blood Transfusion	114	159	71.7%	95%	No
Conflict Resolution	112	159	70.4%	95%	No
Delirium	114	159	71.7%	95%	No
Dementia Training	112	159	70.4%	95%	No
Emergency Planning	109	159	68.6%	95%	No
Equality and Diversity	112	159	70.4%	95%	No
Fire Safety	119	159	74.8%	95%	No
Health and Safety	105	159	66.0%	95%	No
Infection Prevention		159	0.0%	95%	No
Information Governance Clinical	115	159	72.3%	95%	No
Medical Devices	113	159	71.1%	95%	No
Medicine Safety	110	159	69.2%	95%	No
Moving and Handling Clinical	109	159	68.6%	95%	No
Resuscitation	118	159	74.2%	95%	No
Safe Use of Insulin	93	159	58.5%	95%	No
Slips Trips and Falls Clinical	110	159	69.2%	95%	No

Royal Albert Edward Infirmary

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in surgery at the Royal Albert Edward Infirmary is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-fraud awareness	333	352	94.6%	95%	No
Blood collection	301	352	85.5%	95%	No
Blood transfusion	292	352	83.0%	95%	No
Bowel management programme	334	352	94.9%	95%	No
Conflict resolution	329	352	93.5%	95%	No
Delirium	149	352	42.3%	95%	No
Dementia training	334	352	94.9%	95%	No
Emergency planning	331	352	94.0%	95%	No
Equality and diversity	329	352	93.5%	95%	No
Fire safety	339	352	96.3%	95%	Yes
Health and safety	329	352	93.5%	95%	No
Infection prevention		352	0.0%	95%	No
Information governance clinical	332	352	94.3%	95%	No

Medical devices	332	352	94.3%	95%	No
Medicine safety	333	352	94.6%	95%	No
Moving and handling clinical	329	352	93.5%	95%	No
Resuscitation	334	352	94.9%	95%	No
Safe use of insulin	306	352	86.9%	95%	No
Slips trips and falls clinical	327	352	92.9%	95%	No

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff in surgery at the Royal Albert Edward Infirmary is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-fraud awareness	110	127	86.6%	95%	No
Blood collection	110	127	86.6%	95%	No
Blood transfusion	109	127	85.8%	95%	No
Conflict resolution	107	127	84.3%	95%	No
Delirium	109	127	85.8%	95%	No
Dementia training	107	127	84.3%	95%	No
Emergency planning	104	127	81.9%	95%	No
Equality and diversity	107	127	84.3%	95%	No
Fire safety	114	127	89.8%	95%	No
Health and safety	101	127	79.5%	95%	No
Infection prevention		127	0.0%	95%	No
Information governance clinical	110	127	86.6%	95%	No
Medical devices	109	127	85.8%	95%	No
Medicine safety	106	127	83.5%	95%	No
Moving and handling clinical	105	127	82.7%	95%	No
Resuscitation	113	127	89.0%	95%	No
Safe use of insulin	88	127	69.3%	95%	No
Slips trips and falls clinical	106	127	83.5%	95%	No

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training was completed online and staff were given a 12 month period in which to complete it. Staff had electronic learning records which identified the modules they were required to complete including any additional clinical competencies. Clinical staff completed training on recognising and responding to patients with mental capacity needs and dementia. The record gave them a rolling compliance rate so that they could track their progress.

Managers monitored mandatory training and alerted staff when they needed to update their training. Senior nursing and medical staff received monthly reports which contained mandatory training compliance.

Senior staff were clear that it was the staff member's individual responsibility to ensure that they completed their mandatory training. Staff were expected to complete the required training in work time during less busy periods. Staff who fell behind with the training were given allocated time to complete it. We were told that staff could access their mandatory training records at home and

would receive their time back if they did this.

Safeguarding

Staff understood how to protect adult patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, medical staff had a low training compliance for Safeguarding Children level 3.

The trust was unable to provide us with accurate training safeguarding training compliance data ahead of our inspection. We requested the information whilst onsite and we were provided with the tables below. The information details the compliance rate for staff split into the divisions however it does not break it down into hospital side or professional group.

Safeguarding training completion rates

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Prevent	421	455	92.5%	95%	No
Safeguarding Vulnerable Adults	431	455	94.7%	95%	No
Safeguarding Children Level 2	245	254	96.5%	95%	Yes
Safeguarding Children Level 3	171	201	85.1%	95%	No

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Prevent	3	6	50.00%	95%	Yes
Safeguarding Vulnerable Adults	4	6	66.67%	95%	No
Safeguarding Children Level 3	1	2	50.00%	95%	No
Safeguarding Children Level 2	4	4	100.00%	95%	Yes

Royal Albert Edward Infirmary

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in surgery at the Royal Albert Edward Infirmary is shown below:

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Prevent	321	352	91.2%	95%	No
Safeguarding Vulnerable Adults	332	352	94.3%	95%	No
Safeguarding Children Level 2	195	203	96.1%	95%	Yes
Safeguarding Children Level 3	132	149	88.6%	95%	No

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff in surgery at the Royal Albert Edward Infirmary is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Prevent	95	95	100.0%	95%	Yes
Safeguarding Vulnerable Adults	95	95	100.0%	95%	Yes
Safeguarding Children Level 2	80	80	100.0%	95%	Yes
Safeguarding Children Level 3	4	15	26.7%	95%	No

The wards provided a primarily adult service to patients over the age of 18. However, staff on some of the wards told us that they sometimes provided care to older children who were between the ages of 16 and 18. Staff on the wards described how they would accommodate patients in this age range in a side room. We observed that a patient within this age range had been admitted to a ward we visited during our inspection and we saw that they had been given a side room and were accompanied by their family member.

The theatres department had a mixed caseload and regularly treated children. Between October 2018 and September 2019. The table shows that The Royal Albert Edward Infirmary site treated 1,247 children of all ages.

The theatre service ensured that paediatric lists were separate to those of the adults and there was a separate recovery area for children. However, we were told that children treated in the department were in the main not accompanied by a paediatric trained nurse in line with their process as outlined by the senior leadership team. We were told that children were always accompanied by a paediatric anaesthetist.

The paediatric anaesthetist had received safeguarding level three training. However, staff we spoke with, which included nursing and support staff, were unsure as to what level of paediatric safeguarding training they had received. The theatre co-ordinator identified that staff had received safeguarding level two training for children. Staff we spoke with could not identify who had received level three training.

We saw that a number of nursing staff across the core service had received safeguarding children level three training and compliance was close to the trusts target.

Following the inspection the trust informed us that it had reviewed the requirements for safeguarding children level three training against the most up-to-date guidance for medical staff.

The only member of medical staff that required level three safeguarding children training was the trust's lead paediatric anaesthetist and this member of staff was compliant. "At the time of the inspection clinical staff were not yet trained to level three adult safeguarding, as set out in the intercollegiate guidance Adult Safeguarding: Roles and Competencies for Health Care Staff. However, the trust was starting training in December 2019. The guidance expects that all staff will have achieved the appropriate competencies as set out in the guidance by 2021.

The trust had a safeguarding team where staff could raise their concerns or seek advice, the team was available Monday to Friday. Staff we spoke with were aware of how to contact the team and could describe the process for raising a safeguarding concern. In addition, staff had access to a safeguarding flow chart which directed them to the appropriate lines of escalation if they identified a concern and provided contact details for the trust's safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with could describe a safeguarding concern and we were provided examples of concerns which they had escalated in the past.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Each area we visited looked visibly clean and tidy and had sufficient handwashing facilities available. All hand sanitiser dispensers were automatic and contained sufficient product. There was personal protective equipment available to staff such as aprons and gloves and we saw that there was separate equipment for each side room located on the main corridor. We observed staff using the equipment appropriately and adhering to the precautions identified on the boards. In addition, we observed all staff undertaking regular handwashing and use of alcohol gel, which included washing hands between patients.

We observed that staff on wards and in theatres adhered to the uniform policy. Ward staff followed bare below the elbows principles. In theatres there was a clog cleaning station which we observed staff using when they left the theatres prior to entering the changing rooms.

There was a colour coding system in place for mops and aprons dependant on the duties being undertaken. The service used 'I am clean' stickers to indicate when equipment was clean and ready to use.

Wards we visited had sufficient side rooms which could be used to isolate patients who were at risk of infection or those who were suspected to have infection. The hospital had an isolation ward where patients who were confirmed to have infections were transferred to and treated. We were told this was used, for example, if a patient had confirmed clostridium Difficile (C-Diff). We were told that these patients would be reviewed by the medical team identified for outlying patients.

The service used isolation precaution boards to indicate when a patient had infection or was at risk of infection. We saw that these were in use on the wards we visited. The boards had sections to indicate to staff what precautions were required prior to entering the room to be tailored to each patient's condition, these included what personal protective equipment should be worn.

Public Health England encourages trusts to report surgical site infection data against 17 categories. Four of these (all orthopaedic) are mandatory and there is a requirement to conduct surveillance for at least one orthopaedic category for one period in the financial year. The remaining 13 categories can be reported against on a voluntary basis. The trust provided evidence that they had submitted surveillance data for every hip and knee joint replacement and long bone

and neck of femur fracture fixation. They submitted quarterly data to Public Health England on a rolling 12 month data collection programme. Clinician diagnosed surgical site infections were confirmed using a root cause analysis. The findings were entered into a database, which could be audited.

The trust reported April 2018 to March 2019 a surgical site infection rate in joint replacement surgery as an average of 0.5% and trauma fixations as an average of 0.4%. The results broken down showed there were 14 joint replacement surgical site infections out of 2869 procedures and one trauma fixation infection out of 373 procedures. The rates for the previous 12 months were 0.6% for joint replacements and 0.9% for trauma. The results demonstrated that the trust's infection rates remained in line with the limits for Public Health England's regulations. The service monitored the themes and trends identified as part of the root cause analysis process. It had been identified that there were no re-occurring concerns which required them to take action to improve.

The service did not audit against the voluntary categories for general surgery and did not have a surveillance nurse in post for this. Patient reported surgical site infections were monitored using a 30 to 60 day post-operative questionnaire. This was used as a warning tool, to monitor potential surgical site infections. If there was an increase in reported infections, then investigations would be undertaken with a focus on improvement. The service also monitored prophylactic antibiotic usage, which is used to prevent infections occurring and reported 99% compliance for the prescribing of these in the last 12 months.

Wards monitored and displayed in public areas infection rates for methicillin resistant staphylococcus aureus (MRSA) and clostridium difficile (C-Diff). In the areas we visited we observed that there had been no instances of MRSA in some areas for a number of years with the most recent being January 2019 on Swinley Ward. The results for C-Diff were also positive with the most recent being on Langtree ward in September 2019.

There were monthly hand hygiene audits for all departments within the service which were undertaken by the infection prevention and control team. Ward managers received the results and action plans were put in place for improvement where necessary. During our inspection we saw that for September 2019 the Theatre department achieved 100% compliance on the audit.

There was a service level agreement in place with an accredited external company for the decontamination of surgical equipment. We were told that the theatre leads met monthly with the company to discuss issues, concerns and incidents relating to surgical equipment.

There were cleaning schedules in place for the areas we visited. These covered cleaning responsibilities for domestic staff, nursing and support staff. We reviewed the cleaning schedules and saw an inconsistent approach to the completion of these. On Swinley Ward we saw that not all areas of the weekly schedules were completed consistently, and we found that the daily cleaning schedules were consistently not completed during the weekends. House keepers who were responsible for the cleaning schedules worked Monday to Saturday. The schedules were audited monthly by the infection prevention and control team for the trust. We were given an example of recent feedback from the audit which related to the cleaning of fans as a result we were told the fans were taken apart and cleaned on a weekly basis as part of the checklist.

Environment and equipment

The use of facilities and premises did not always meet with updated standards to keep people safe and we found hazardous substances stored in unlocked rooms which could be accessed by patients and visitors. We found that there were not always effective processes in place to ensure that sundries used by staff were in date and safe to use. However, the

design, maintenance and use of equipment in the main kept people safe and staff were trained to use them. Staff managed clinical waste well.

On the wards we visited we found that not all dirty utility rooms were lockable this included Swinley, Orrell and Langtree wards. We observed that there was cleaning fluids on the side in the dirty utility rooms on these three wards, which could be accessible to unauthorised persons and posed a risk to patients safety. The cleaning products we observed were chlorine based solutions, cream cleaner and stainless steel cleaner all of which identified they were hazardous to health on the warning labels. There had been an estates and facilities alert in 2019 which required providers to ensure that hazardous cleaning fluids could not be accessed by patients or visitors. Following our inspection, the trust provided a copy of their response to the estates and facilities alert, which was dated 6 June 2019. The response identified actions had been taken, however this did not reference the dirty utility doors, which were not lockable, and it was not clear what storage categorisation they had allocated the chlorine based solution. We raised this with the trust at the time and cleaning products were removed.

We saw that the theatres department had identified the environment of theatres one, two and six as a risk, due to concerns about the air flow systems. This was displayed on the governance board in staff areas. The senior leadership team identified that they were no longer functioning to the current health technical memorandum guidelines HTM03-01 and HTM 025. We saw that there were risk assessments in place for the affected theatres with mitigating actions in place to reduce the risk. This meant ensuring theatre doors were closed and only one door used to gain access and exit and not using the theatre for specific procedures which were considered to be of a higher risk. Staff were aware of the risk assessments and associated actions and we were told that there were spot check audits in place to monitor compliance. There were plans to update the airflow system in the next two years.

Staff had access to adequate sundries (for example dressings, needles and syringes). We reviewed 218 sundries across the service in the different areas we visited. We found that in the main they were clean, intact and within the manufacturers' recommended expiry dates, however we did find some which had exceeded the recommended expiry dates. In the maxillo facial surgery department, we found 169 expired items which included syringes, monitoring sensors and needles, on Aspull Ward we found one pack of expired gloves and on Swinley Ward we found 22 needle cannulas. Some expired items dated back to 2013. We raised this with leads of the areas at the time of our inspection who took appropriate action.

The maxillo facial surgery service had identified environmental issues as their top risks on the risk register. This included the environment being small, difficulties with space for storage and the cabinets being old and outdated. Clinic rooms were part of a rolling update plan which included new mechanical chairs. Staff reported that due to the construction of the rooms and the adjoining door they did not provide the level of privacy and dignity they would have hoped for and discussions could be heard in the adjoining rooms. We were told that they had started to use a consultation room in the pre-operative clinic which provided more privacy for more sensitive discussions.

Each department we visited had sufficient access to resuscitation trolleys which were kept in accessible areas. In addition, the theatres department had a separate paediatric resuscitation trolley. The trust had a system where all trolleys were standardised so that staff knew where to find what they needed in the event of an emergency situation. Completion of the daily trolley checks were audited by the trust's resuscitation team monthly.

We reviewed seven resuscitation trolleys across the service including the paediatric resuscitation trolley in the theatres department. In the main we found that daily checks had been completed as per the trust's policy and we sampled equipment and sundries and found that in the main the required equipment was present and within manufactures expiry dates. However, in the maxillo facial surgery department we found a missing needle from one of the drawers and the oxygen had expired in July 2018. The trolley in the main theatres department had six days where the daily checks had not been completed.

We saw an inconsistent approach to the checking of the additional emergency trolleys in the theatre department. We reviewed the daily checklist for the difficult intubation trolley and found that there were two days where the trolley had not been checked, and we found an incomplete checklist.

The theatres were secured from unauthorised access from the main corridor by door which required swipe card access. There was a reception area for persons to report to who were visiting the department.

The theatre department had a recovery area which had been split into adult and paediatric so that children were cared for separately. In addition, there was a separate temporary recovery area for maternity patients which had been introduced following the service taking on elective caesarean sections.

The trauma and orthopaedic ward had 20 weighing beds which enabled patients who were not mobile particularly those with hip fractures to be weighed on the bed so that medicines and nutritional needs could be appropriately assessed. We observed that weighing scales in all areas had been recently calibrated and had labels identifying when they were next due.

There was an electrical and biomedical engineering department who was responsible for the maintenance and service of electrical equipment across the trust. Equipment servicing which was managed and maintained by the team were monitored using a database and reviewed at the medical equipment management group through quarterly reports. Specialist equipment which was maintained by the manufacturer or external companies were overseen by the lead for that area. We reviewed 24 pieces of electrical equipment across surgery and found that in the main equipment had been serviced within its re-test dates and had stickers to identify when the next service was due. We found one blood pressure monitoring machine which was outside of its service date, we raised this with staff at the time of our inspection.

The maxillo facial surgery department had access packs which were made up of sterile equipment and sundries for specific procedures, by an external company. The packs were developed with staff on the unit and contained everything they needed to perform specific procedures.

We observed appropriate waste segregation which were labelled and identifiable. There were bins available in patient areas which were clearly marked for clinical and domestic waste. Sharps bins had been correctly assembled and labelled, however, we found that three of the bins on wards in patient areas did not have the sharps guard across.

Every ward had a staff board on entry displaying staffing It displayed visiting times, protected meal times, information about what the different coloured staff uniforms meant and safety thermometer information. We checked patient toilets and showers on some of the wards we visited and found in the main they were clean, and all those we checked contained an emergency pull cord.

Call bells were in reach of patient beds, and the patients we spoke with told us that staff responded promptly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, training compliance for paediatric life support for theatre staff was low and there was a risk that there were not enough staff who had the required level of training.

In theatres the paediatric anaesthetists had advanced paediatric life support training and we were told that there were always two paediatric anaesthetists present during paediatric theatre lists. Staff working in theatres told us that they had not received basic paediatric life support training. We were told that when children were treated in theatre recovery without the presence of a paediatric trained nurse this was done by recovery staff. We requested compliance rates for paediatric life support training for the department the service confirmed that 36% of Anaesthetists undertaking paediatric theatre Lists were compliant with paediatric resuscitation training and 50% of theatre recovery/anaesthetics staff had received the training in 2017.

There was a risk that staff present during theatre lists for children did not have the appropriate level of resuscitation training and that their training was not up to date. Following our inspection, we requested assurance that the trust had suitably trained staff to keep patients safe. The trust provided information which identified there would be a review of the training and provided timescales for the training to be completed and up to date by the end of December 2019.

In the maxillo facial surgery department band two and four staff had basic life support training, the band five and six nurses and the consultant had received adult intermediate life support training. In addition, the consultant for the service and two senior nurses were trained in paediatric intermediate life support.

The theatres department had an emergency response station which had been implemented by a member of theatre support staff who had won an award for the initiative. The station contained the resuscitation trolley, difficult airway trolley and additional equipment. In addition, there were clipboards attached to the wall which clearly stated which emergency they related to and they contained information and algorithms for staff to follow for each identified emergency situation. This included anaphylaxis, anaesthetic toxicity and malignant hyperthermia. We were told that it was the responsibility of the member of staff who had implemented the system to ensure all of the information was kept up to date.

The service used an internationally recognised scoring system, American Society of Anaesthesiologists (ASA), during the pre-operative assessment process to identify how high risk a patient was for surgery. The Royal Albert Edward Infirmary site treated elective orthopaedic patients who had been identified as ‘high risk’ this was based on an ASA score of four and above. High risk patients were treated at the site due to the immediate access to higher levels of care if a patient required it, such as the high dependency unit and the intensive care unit.

Patients who were having day case surgery were assessed for their suitability for nurse led discharge and recovery. The day case recovery unit only accepted patients who scored two on the ASA were identified as suitable for nurse led discharge. In addition, prior to their surgery these patients were reviewed by the anaesthetist to provide a second opinion to make sure they were suitable for a nurse led discharge if not they would be recovered and discharged in the main theatres department.

Staff completed patient risk assessments at pre-assessment clinics prior to patients attending for surgery, which included screening for Methicillin-resistant Staphylococcus aureus (MRSA) and provided treatment for this if it was identified as required.

On the day of surgery, nursing staff completed updated risk assessment for patients. This identified any changes in the patient's condition and care needs since their preoperative assessment. Nursing staff completed standardised risk assessments for patients' care plans these included falls, malnutrition universal screening tools and venous thromboembolism risk assessments. We reviewed 20 patient records and saw that these were completed appropriately. For those patients who were identified as being at risk, precautions to mitigate these were recorded. Review found evidence of referrals to appropriate specialities such as dietitians and speech and language therapy.

The service used a nationally recognised tool for identifying when a patient is showing signs of deterioration which is known as National Early Warning Scores (NEWS2). Staff received training about the use of the scoring tool on an e-learning package. Nursing and medical staff we spoke with were aware of the process to escalate patients who were at risk of or were showing signs of deterioration. Staff knew how to access the policy if they needed to. NEWS2 scores were inputted into the electronic patient record and the system identified the time frames required for re-assessment based on the scores. Patients who were scoring as at risk in their NEWS2 scores were reviewed by the critical care outreach team who were altered via the electronic system. In addition, staff had access to the outreach team for advice and information via a bleep number if they had concerns about a patient. Staff spoke highly of the support they received from the critical care outreach team. The appropriate use of NEWS2 was audited on a monthly basis by the sepsis nurse and feedback and additional training was given to ward staff as needed. Ward managers could monitor compliance against the audit via the performance dashboard application.

We reviewed the audit of Langtree ward compliance for October 2019 at the time of our inspection the ward scored 99.2% compliance with what they had inputted into the system and the actions taken and 75.3% compliance with the timeliness of the re-assessments.

The theatre department had modified the national early warning scores (NEWS2) for use on patients who were being treated in theatre recovery after having their surgery. The charts used to record the scores had been modified to reflect this. We observed staff in theatre recovery undertaking observations of patients and completing the appropriate documentation.

The service used a nationally recognised care bundle for suspected and confirmed sepsis. There were red sepsis boxes available on wards which contained vital equipment and medicines for staff to use for patients who were suspected of having sepsis. Staff received sepsis training as part of their mandatory training which was delivered by the sepsis specialist nurse for the trust and there were e-learning packages available to staff. Each ward had a sepsis link nurse who cascaded information and training to the teams. In addition, documentation was audited regularly in relation to the management of sepsis and the escalation of national early warning scores. Nurses who had received training in cannulation and taking blood tests could access additional training to take the blood samples to test for sepsis.

The service used World Health Organisation (WHO) checklists to ensure the safety of operations. The completion of WHO checklists was audited on a monthly basis and the results were split into two categories quantity and quality. During our inspection we saw that results were displayed in the theatre department in staff areas on the governance notice board. At the time of our inspection the results for September 2019 were displayed, we saw that the department had achieved 100% for quantity which meant that all components of the checklist were completed and 99% for quality which is a random observed practice and reflects how staff engage with the process. The service reported that between April 2018 and March 2019 they achieved 100% compliance for the completion of the WHO checklist.

As part of the five steps to safer surgery the theatre department used a counting out process for equipment used during an operation. The equipment was listed on a board in the theatre. We observed that equipment was counted in and out during the operation process. This was then completed on the WHO checklist. We observed the completion of the WHO checklist for three procedures and we saw that all staff were engaged and involved, all steps were followed and we observed that the information was documented on the electronic system in the patients records.

The service used NHS England National Safety Standards for Invasive Procedures (NatSSIPs), and Local Safety Standards for Invasive Procedures (LocSSIPs) for a range of procedures in theatres and on the wards. There was a folder located in theatres where information about local safety standards for invasive procedures were held.

We saw that the top three local risks were displayed in staff areas across the surgery departments and staff were aware of the risks to their areas.

The theatre had a daily communication cell each morning prior to the theatre list starting which all theatre staff attended. The communication cell followed a standardised agenda which looked at a number of different safety and communication aspects. These included staffing, equipment needs, high risk patients, incidents and vital equipment checks. The meetings were documented on the check sheets however upon review of these we saw that they were not consistently recorded. Senior nursing staff in the department agreed that there was limited assurance that each aspect was covered, and this did not provide a clear audit trail.

Theatre team briefs were undertaken twice daily and included the theatre team involved in the list. We observed a theatre team brief and saw that all staff were involved and engaged in the discussion. We saw that staff introduced themselves and their roles, each patient and their procedure was discussed, risk factors were discussed such as allergies and past medical history, equipment requirements, and anaesthetic needs and equipment were discussed.

The surgical admissions unit had a daily safety huddle in the morning where they discussed staffing, each patient and patients requiring additional support to ensure that the appropriate plan and support was in place, shared incidents or complaints and any positive feedback.

Staff shared key information to keep patients safe when handing over their care to others. Nursing and medical handovers took place twice daily. Nursing staff who were not on the standard long day shifts had additional handovers at their start times. We saw that there were standardised forms used for handovers where the information was documented we observed all necessary key information to keep patients safe was covered which included risk factors and completion of risk assessments.

Nurse staffing

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

Staffing for each shift was displayed on staffing boards outside of each ward which indicated the planned staffing against what they actually had for that day. During our inspection we observed that in the main, staffing met with the planned figures. There were some occasions where staffing did not meet with the expected numbers, however, we saw that in some of those cases the nurse staffing was then supported with an assistant practitioner role or additional support staff.

Senior nursing staff on the wards had access to a ‘safe care application’ which was accessed through an electronic device. The application worked out staffing according to care hours which is

a nationally recognised standard. The senior nursing staff inputted into the application the staff rostered that day and the acuity of the patients, the application then worked out the care hours required for each shift and indicated if the staffing was adequate to meet the patients' needs. We were told senior nursing staff updated the application three times per day and they were able to make requests for additional staff based on this. Staff were positive about the application and felt it made obtaining more staff an easier process. The application also allowed the senior staff to see what the staffing picture was across other wards and identify where support could be accessed internally prior to requesting external staff.

There were matrons who had oversight of the wards at Royal Albert Edward Infirmary. Senior nursing staff spoke positively about the support they received from the matrons particularly with moving staff between the wards to meet the needs of the patients. In addition, staff working in trauma and orthopaedics provided cross site cover for Wrightington Hospital and Royal Albert Edward Infirmary to support staffing numbers as required. However, we were told staff were not always happy about working across sites. This was acknowledged by senior staff and an escalation process was implemented which required approval prior to moving staff.

There were 106 theatre staff which equated to 90 whole time equivalents who worked across the six theatres. Theatre staffing was planned in line with The Association for Perioperative Practice guidelines. Theatre staffing was planned six weeks in advance according to the planned lists, staffing was approved and locked three weeks in advance. This meant that additional patients could not be added to the theatre lists without prior approval and appropriate uplift of staff. We were told that the department always adhered to the guidelines.

Theatres identified a minimum number of support staff who could assist during paediatric theatre lists and these staff were always assigned to the paediatric cases. This was to ensure that staff supporting those operations had more experience and knowledge with paediatric cases.

The maxillo facial surgery department had nurse staffing which was made up different grades of staff who were led by a unit sister. At the time of our inspection they reported low vacancies. There were nurses who had extended roles and could undertake some procedures that would routinely be undertaken by the medical staff.

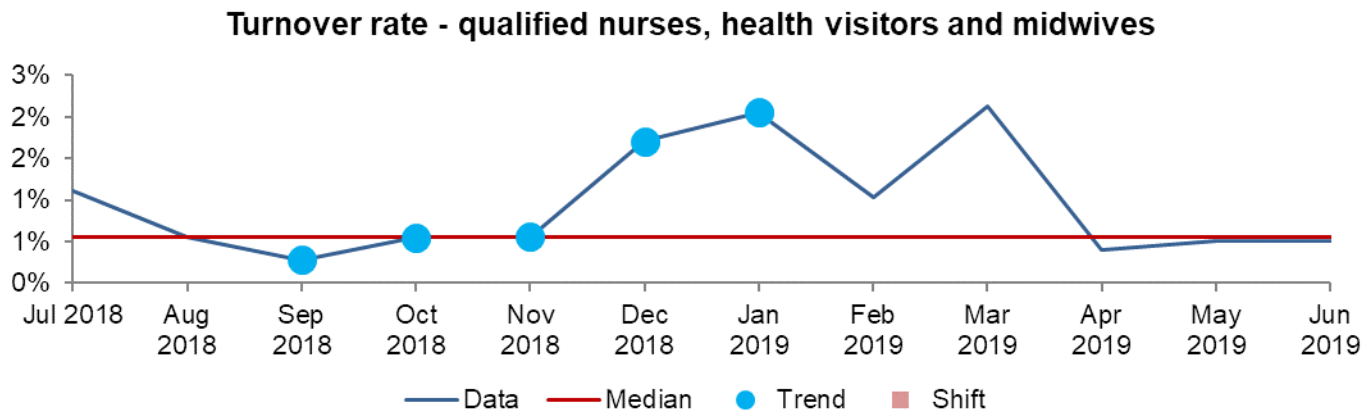
Trust level

The table below shows a summary of the nursing staffing metrics in surgery at trust level compared to the trust's targets, where applicable:

	Surgery annual staffing metrics						
	July 2018 – June 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		4%	9%	4.0%			
All staff	1,217.2	8%	12%	4.7%			
Qualified nurses	476.9	9%	11%	4.6%	20,455 (30%)	1,747 (3%)	22,201 (33%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

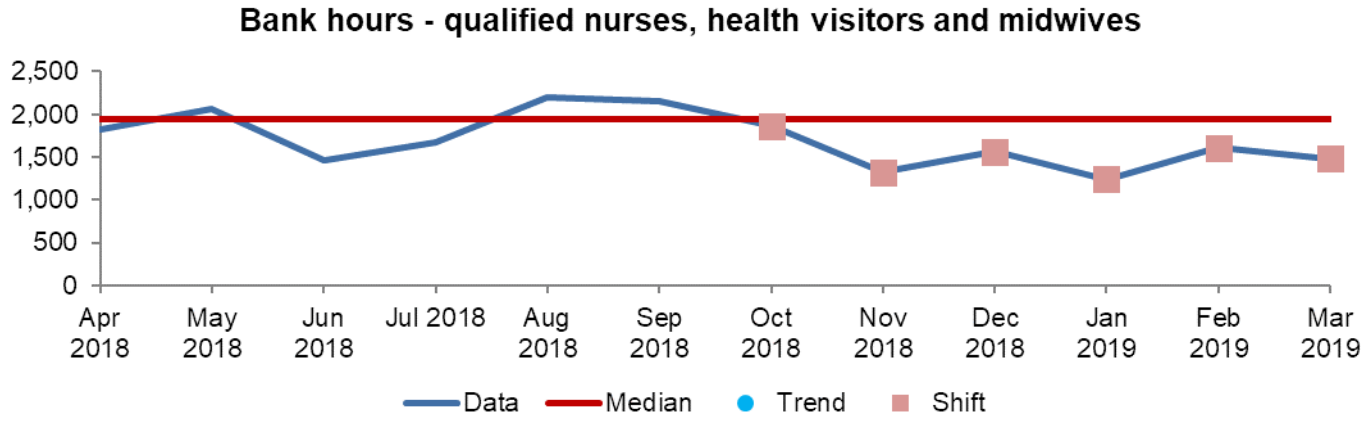
Turnover rates



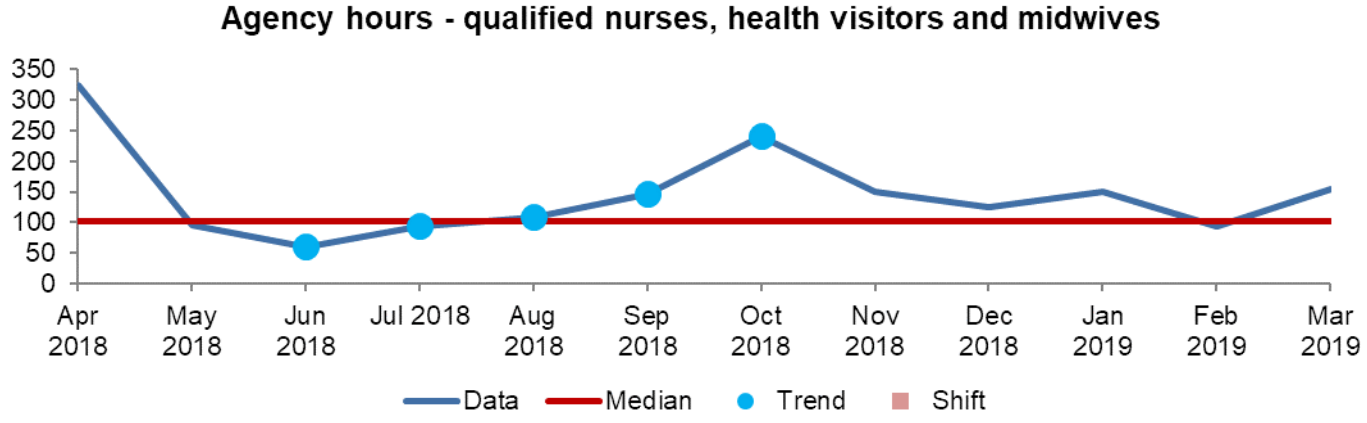
Monthly turnover rates over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from September 2018 to January 2019. Though this had improved to below 1% by April 2019.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Bank and agency staff usage



Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives shows a shift from October 2018 to March 2019.



Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from June 2018 to October 2018.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Royal Albert Edward Infirmary

The table below shows a summary of the nursing staffing metrics in surgery at the Royal Albert Edward Infirmary compared to the trust's targets, where applicable:

	Surgery annual staffing metrics July 2018 – June 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		4%	9%	4.0%			
All staff	543.4	10%	13%	4.1%			
Qualified nurses	188.5	11%	14%	3.3%	8,478 (26%)	782 (2%)	9,260 (28%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within surgery at the Royal Albert Edward Infirmary were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for bank and agency use.

The service had an approved bank and agency provider. We were told that there was no senior approval required to request staffing if unfilled shifts had been identified. Bank and agency staff had local inductions which covered orientation and the review of relevant policies and procedures.

In the theatres department agency staff were approved dependant on their skills and qualifications which were confirmed with the agency. They were given a separate induction to substantive staff. The induction included orientation of the department, reading of policies and procedures and a check of the staffs skills and competencies. Agency staff were given a buddy for support during their induction process.

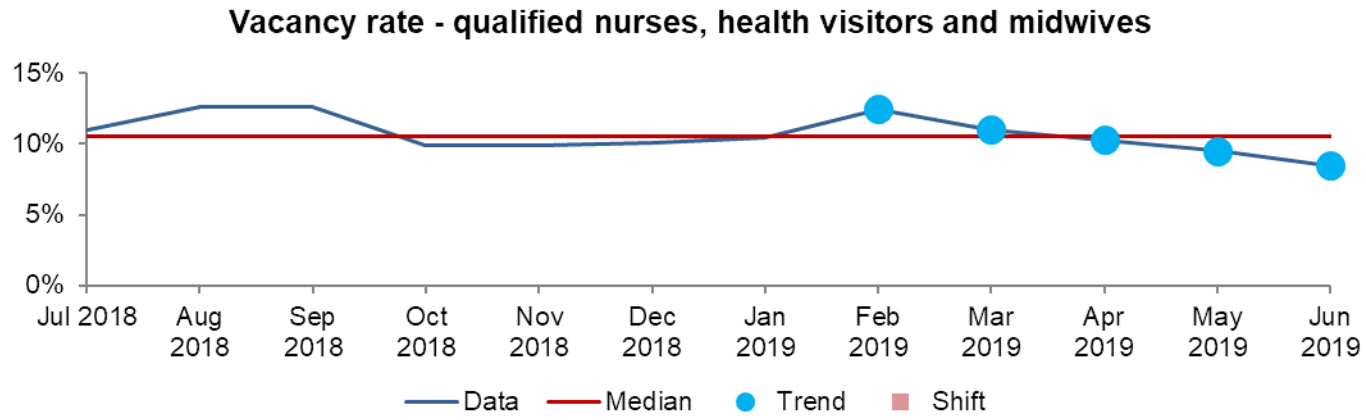
The theatre department had recently expanded its services to provide two elective caesarean section lists per week. At the time of our inspection the business case for the additional staff to provide this service had not been finalised. We were told that this had an impact of the surgical staff and meant additional staff were being provided through the use of agency. There was a theatre co-ordinator who was responsible for overseeing the service and supporting the staff within the team.

Theatre staffing was assessed and monitored on a daily basis. At the time of our inspection the service reported it was using a number of agency staff to provide safe staffing. Agency usage was reported as four in scrub, three in anaesthetics, two in recovery and one in cancer lists. We were told that the agency staff used were often regular and were familiar with the department.

The wards used an agency to access enhanced care support staff. Nursing leads could request additional support for patients who were assessed as being high risk due to their enhanced care needs. Senior nursing staff were supported by the trust to utilise the additional support which was provided at an extra cost so that patients were supported. The trust used a specialist agency which provided specialist support workers who had additional training in enhanced care. The

agency staff provided one to one care twenty four hours a day seven days a week for patients who required it. We spoke with some of the support workers who told us they had a good induction and were supported by the ward team.

Vacancy rates



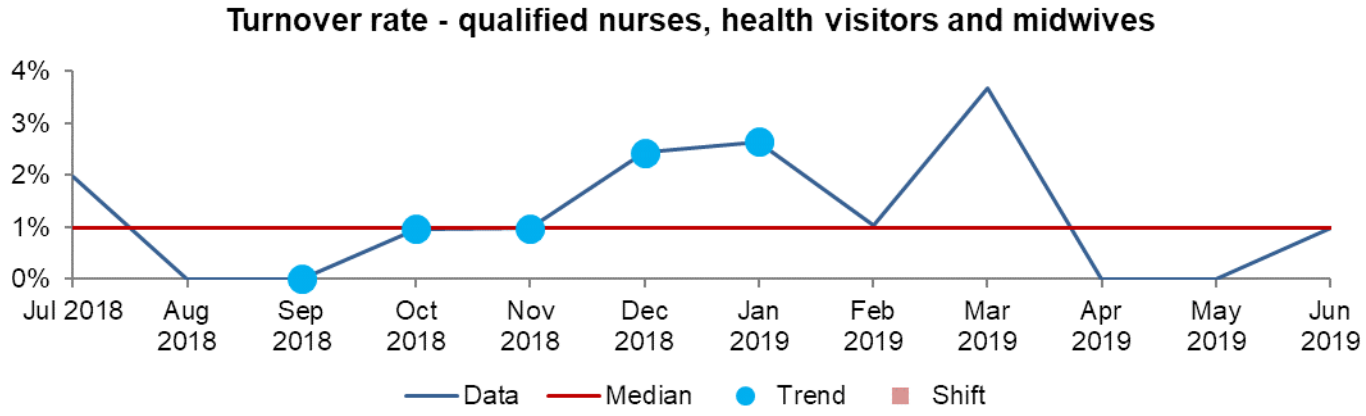
Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a downward trend from February 2019 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

At the time of our inspection theatres reported nursing vacancies of one recovery post, three in anaesthetics and three scrub nurses. At the time of our inspection these roles were out to advert.

Aspull ward reported three registered nurse vacancies one of which had been recruited to and the other two were out to advert. Langtree ward had two registered nurse vacancies which had been appointed to and were due to start in March and two health care assistant posts which were going through the recruitment process. Senior nursing staff told us that there were no concerns with the recruitment of staff and in the main staff had worked at the trust for a number of years.

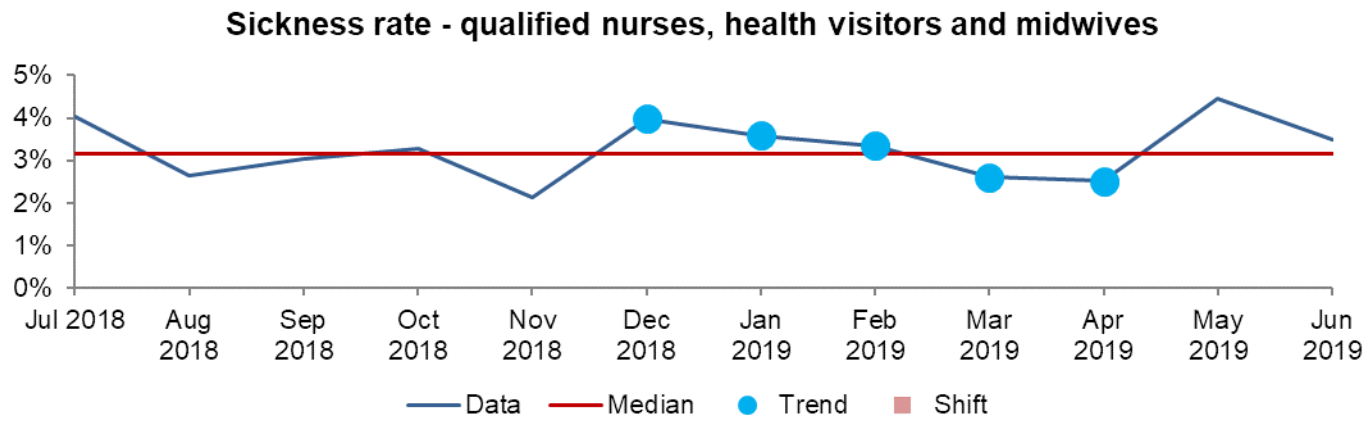
Turnover rates



Monthly turnover rates over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from September 2018 to January 2019. Though improved to below the monthly median from April 2019.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

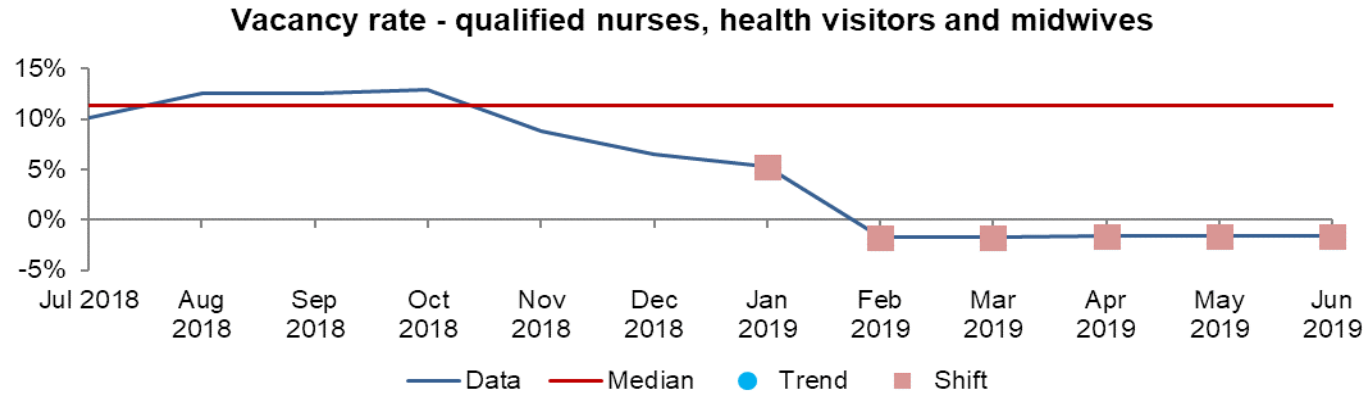


Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives shows a downward trend from December 2018 to April 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

At the time of our inspection the theatre department reported a sickness rate of 3.5%.

Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from January 2019 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Nursing ward handovers took place twice daily for staff on the standard long day shifts. For staff who did not undertake usual working hours there were additional handovers at the start of their shift. We saw that there were standardised forms used for handovers where the information was documented we observed that this covered an overview of each patient and any information that may need to be shared such as risk factors, care plans, completion of risk assessments, social and emotional needs additionally there was discussion about incidents, complaints, audits, a check of daily checks completion such as fridge temperatures and resus trolley checks.

On Aspull ward, the ward manager had additionally introduced a daily ‘round robin’ which took place half way through the day. We were told this was a huddle with each bay to discuss issues, fluid balance chart completion, patient flow and identified discharges and progress with these.

Medical staffing

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

Medical staffing structures were dependant on the speciality. The service had twice daily, or daily ward rounds dependent on the speciality and there were arrangements in place for weekend ward rounds. On call arrangements were in place for each of the specialities, with suitable consultant cover. Staff told us that they had adequate access to on call medical doctors during the weekend and out of hours for patients who required urgent review.

Aspull ward which was a trauma and orthopaedics ward had a daily ward round completed by the Orthogeriatrican. This was in line with the hip fracture pathway and guidance. We were told that the service was currently carrying some vacancies within the Orthogeriatrican team and that this reflected a national shortage. This meant that the ward rounds were only undertaken Monday to Friday and so patients were not reviewed by the Orthogeriatrican during the weekend, however patients were reviewed by the trauma medical team and trauma co-ordinators. Each Friday patients were given a plan to cover the weekend.

Medical handovers took place twice a day at 8.00 am and 8.00 pm, we were told that the evening handovers did not include a consultant.

The maxillofacial surgery department had consultants within differing maxillo facial surgery specialities attached to it these included maxillo facial surgery, orthodontics and oncology. There were four consultants assigned to the service with one being an honorary member of the team. In addition, there was a medical rota of varying grades. Consultants provided clinics and lists on set days of the week.

In the theatres department staffing was planned in line with The Association for Perioperative Practice guidelines. Paediatric theatre lists were assigned two paediatric anaesthetists.

We spoke with trust grade medical staff who told us that they received a thorough induction and had good support from the consultant team.

Trust level

The table below shows a summary of the medical staffing metrics in surgery at trust level compared to the trust's targets, where applicable:

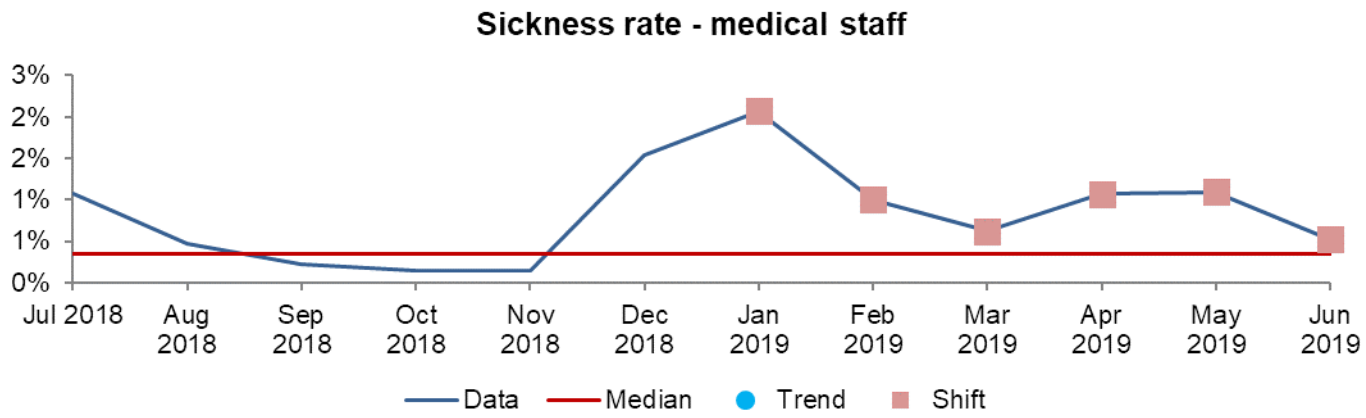
	Surgery annual staffing metrics						
	July 2018 – June 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		4%	9%	4.0%			

All staff	1,217.2	8%	12%	4.7%			
Medical staff	240.1	12%	6%	0.8%	9,026 (2%)	9,234 (2%)	18 (<1%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and turnover.

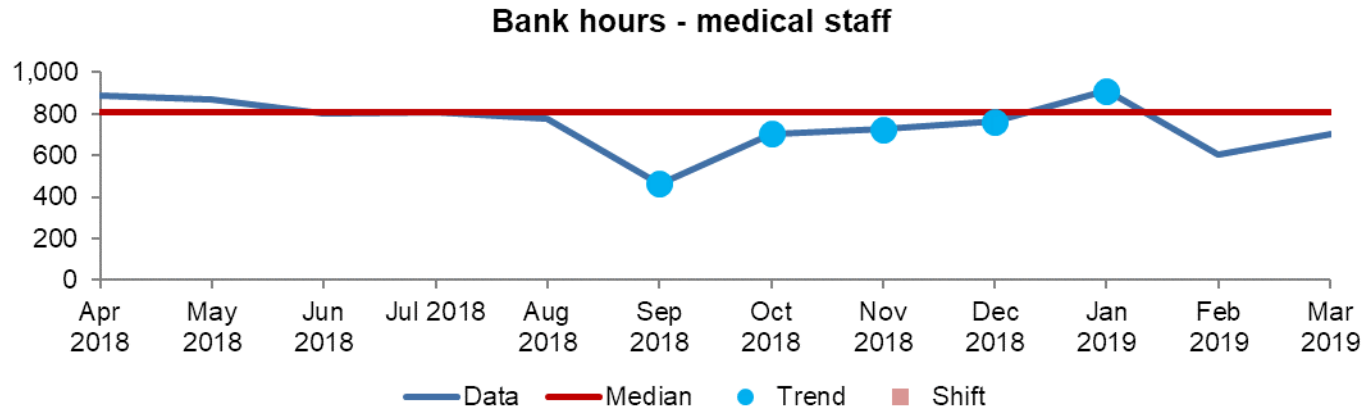
Sickness rates



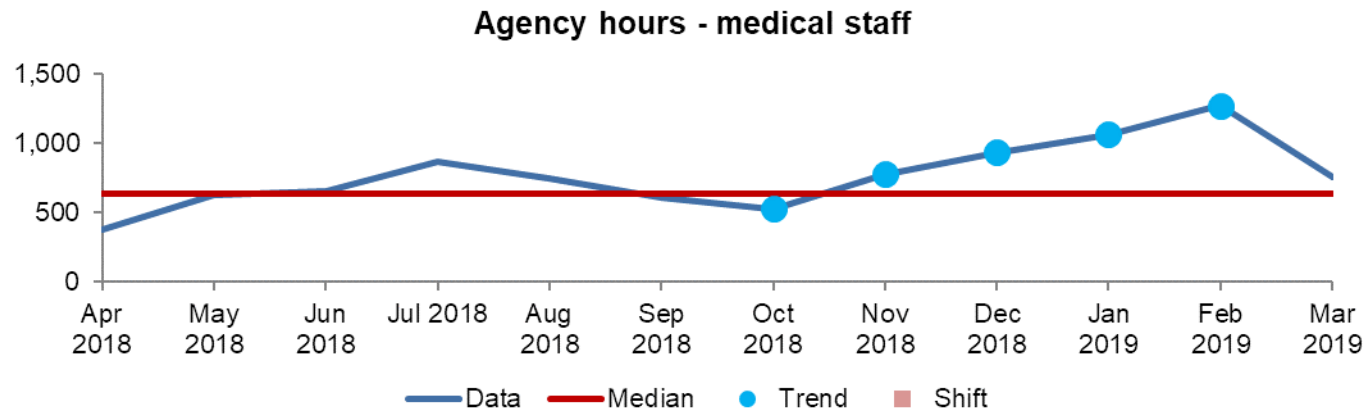
Monthly sickness rates over the last 12 months for medical staff shows a shift from January 2019 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage



Monthly bank hours over the last 12 months for medical staff shows an upward trend from September 2018 to January 2019.



Monthly agency hours over the last 12 months for medical staff shows an upward trend from October 2018 to February 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

Royal Albert Edward Infirmary

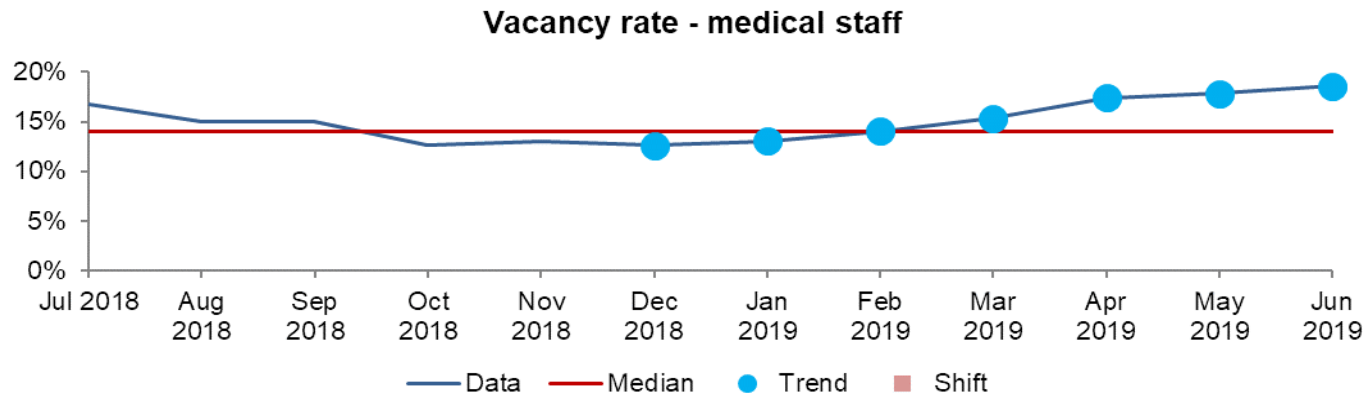
The table below shows a summary of the medical staffing metrics in surgery at the Royal Albert Edward Infirmary compared to the trust's targets, where applicable:

	Surgery annual staffing metrics July 2018 – June 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		4%	9%	4.0%			
All staff	543.4	10%	13%	4.1%			
Medical staff	143.3	15%	7%	1.0%	3,985 (1%)	3,952 (1%)	18 (<1%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within surgery at the Royal Albert Edward Infirmary were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and bank use.

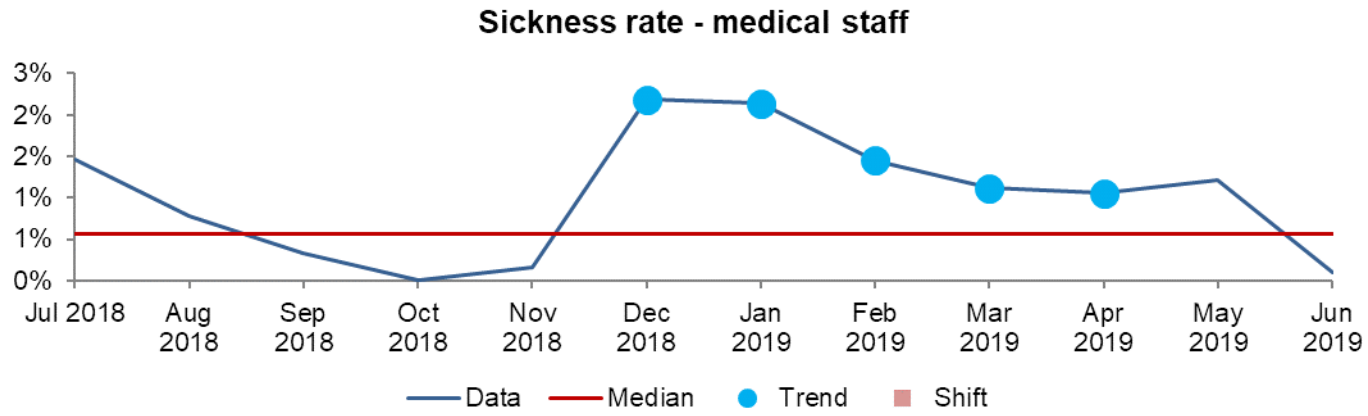
Vacancy rates



Monthly vacancy rates over the last 12 months for medical staff shows an upward trend from December 2018 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

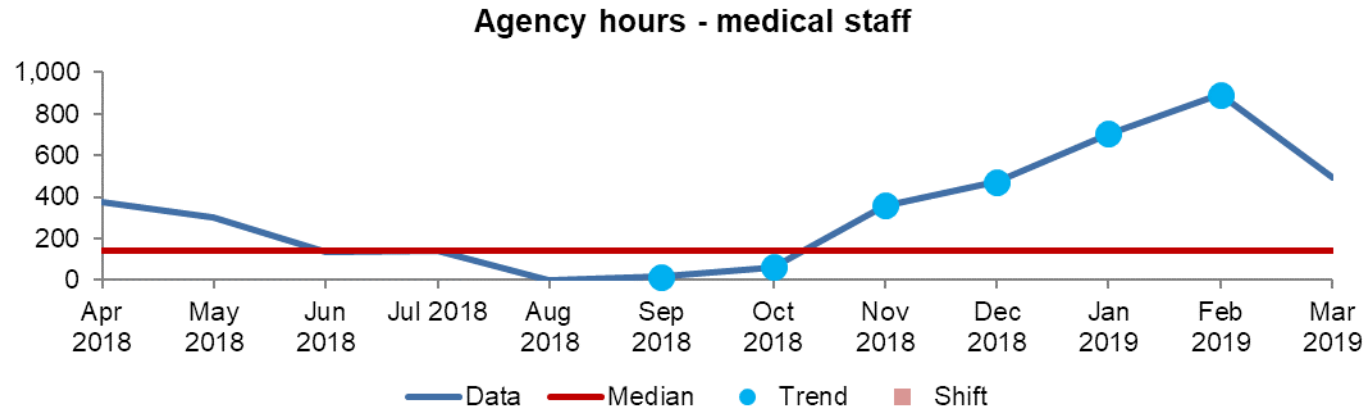
Sickness rates



Monthly sickness rates over the last 12 months for medical staff shows a downward trend from December 2018 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

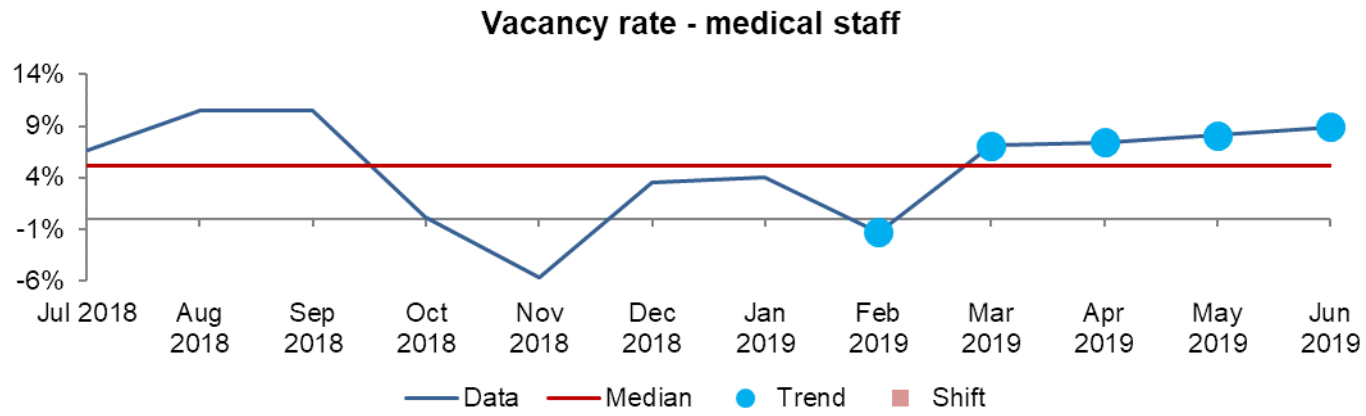
Agency staff usage



Monthly agency hours over the last 12 months for medical staff shows an upward trend from September 2018 to February 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

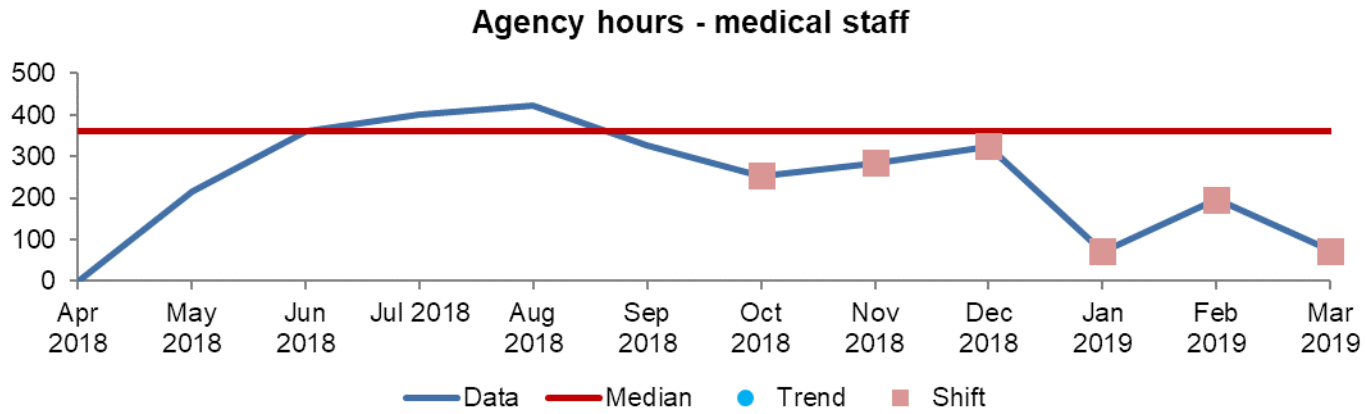
Vacancy rates



Monthly vacancy rates over the last 12 months for medical staff shows an upward trend from February 2019 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Bank staff usage



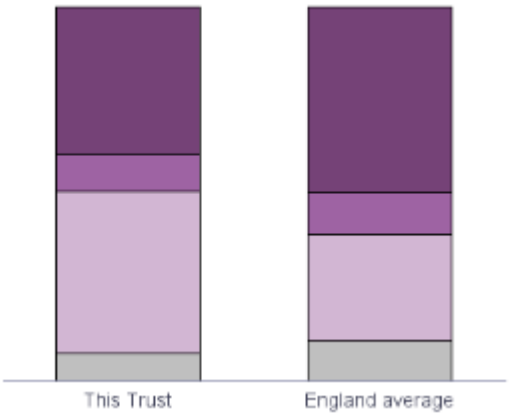
Monthly agency hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

Staffing skill mix

In May 2019, the proportions of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust were lower than the England averages.

Staffing skill mix for the whole time equivalent staff working at Wrightington, Wigan and Leigh NHS Foundation Trust



	This Trust	England average
Consultant	39%	50%
Middle career^	10%	11%
Registrar Group~	43%	28%
Junior*	8%	11%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Medicines

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

Pharmacy team provision for each ward which consisted of a pharmacist and a pharmacy technician. There was a prescribing pharmacist assigned to the service who could prescribe missed medicines or discharge prescriptions. Ward based services were provided Monday to Friday 9am to 5.30pm. The pharmacy department was open and available to staff 8am to 6.30pm. Weekend pharmacy provision was 9am to 5pm for medicine orders and discharge prescriptions. Outside of working hours there was a pharmacist on call to manage queries and urgent requests.

Medicines were stored in locked cupboards which were located in locked clinic rooms. In patient bays on the wards there were metal medicine trolleys which were lockable and tethered to the wall, patient's own medicines were stored in bedside lockers which were secured. Nursing staff held keys to the trolleys and lockers. During our observations we saw that all clinic rooms and medicines cupboards were secure and locked. We observed that in the main medicine trolleys were locked and appropriately tethered to the wall, however we found one trolley on Langtree ward which was not locked and secured to the wall.

Stock medicines were monitored by the pharmacy department who undertook stock top ups on a weekly basis. Outside of the top up service, staff could request stock from the pharmacy team.

The pharmacy department undertook monitoring of compliance with medicines management processes across the hospital. There were monthly audits for safe and secure storage of medicines, pharmacist interventions, omissions, antibiotic prescribing and controlled drug documentation and storage requirements.

In theatres we saw that the most recent results for the controlled drugs audit were displayed in staff areas. The compliance rate for September 2019 was 86%, we were told that the concerns identified related to the documentation in the controlled drug registers.

We reviewed the safe and secure and controlled drug audits for October 2018 to September 2019 in the main we saw that the indicators were green. However, we saw that there were common themes of non-compliance in the theatre department for medicine cupboards and clinic rooms not always being locked and secured and controlled drug stationary not being stored securely, part doses not documented correctly, and the controlled drug register not being completed legibly. For both theatres and the wards there was a theme of the fridge's not being locked when not in use.

The divisional rolling audit for antibiotic stewardship demonstrated that between November 2018 and October 2019 the service achieved 100% compliance, this was an improvement from the previous year in which the service achieved 97%.

Fridge and room temperatures where medicines were stored were checked daily, and we saw that this was consistently completed in all areas we visited and we observed that the temperatures were within the expected range. We observed the fridge in theatre two all temperatures were recorded including min and max. There was a standard operating procedure available for staff which was kept on the front of the fridge for the process of monitoring fridge temperatures and re-setting the thermometer. However, we saw that this did not tell staff what the temperature range should be or outline the escalation process if the temperatures were outside of the recommended range.

The theatre recovery fridge maximum temperature had been recorded as 10 degrees for eight days staff told us the issue had been reported to pharmacy, however this was not documented on the record sheet and so there was no audit trail of this action.

Controlled drugs were kept in separate cupboards within clinic rooms in all areas we visited. We reviewed the controlled drug registers for ward stock and patients own controlled drugs. We found that in the areas we visited all daily checks had been completed and registers matched the stock held within the cupboards. In the theatres department all controlled drugs were checked twice daily by two practitioners. We observed that all documentation had been completed correctly which included the documentation of any waste. Medicines within the cupboard were intact and within manufacturers' recommended expiry dates.

Prescription charts were stored on an electronic patient record system. Staff with the relevant permissions had access to patients' prescription charts for prescribing and administering medicines. We reviewed 21 prescription charts, we saw that medicines reconciliations had been completed and that patients had received a regular pharmacy review of their medicines in line with national guidance. In the main medicines had been appropriately prescribed and administered. We saw evidence that patients had undergone a venous thromboembolism assessment and medicine supplied where appropriate. We saw evidence that antibiotics were prescribed with course lengths and had been reviewed within the review date, as per best practice.

The electronic record system contained a medicine self-administration policy for staff to assess patients against and decide if they were safe to administer their own medicines. We observed staff assessing for self-administer of medicines and the relevant documentation being completed.

There was a focus on supporting patients to manage their own medicines and maintaining their independence whilst they were in hospital. We were told that patients were often assessed against the self-administration policy. Ward staff encouraged patients who required insulin to continue to manage it themselves whilst they were in hospital. We were told that they supported patients who were struggling to manage their insulin to help them improve.

Oncology and colorectal patients were discharged home with anticoagulant injections for 28 days post-operatively to help prevent blood clots following their surgery. Staff told us they taught patients how to administer the injections themselves early on so that they were confident in doing it once they had been discharged from hospital.

We saw nursing staff checking patients details and allergy status when administering medicines. We saw that staff explained what the medicine was used for and provided a clear explanation about the directions of use.

A nurse on Langtree ward had introduced an initiative to improve the timeliness of administering Parkinson's medicines to patients. We were told this was following feedback from a patient, about the timeliness of patients receiving their Parkinson's medicines which was often outside of the usual medicine rounds. The nurse had implemented the use of alarm clocks for these patients which would go off when their next round of medicine was due. We were told that the results had been positive on the ward and as a result the nurse was working to spread the initiative across the trust with the support of some approved funding.

Each ward and the theatres department had a link nurse for medicines management. The link nurses attended additional training and regular meetings to discuss medicines management related issues. On Orrell ward we saw that they had displayed a medicine of the month. We were told this was as a result of medicines errors relating to intravenous antibiotics. We saw that there was information for staff about the errors and learning as a result to improve practice.

Records

Staff kept detailed records of patients' care and treatment. Records were clear and up-to-date and easily available to all staff providing care. However, we found that records were not always stored securely and could be accessed by unauthorised persons.

Most patient records were electronic and accessible through the trust's electronic system. Paper based records were used for fluid balance charts, hourly rounding, insulin sliding scales, food records, behavioural charts (for patients with enhanced care needs) and weight charts. The hip fracture pathways were completed on paper-based documents due to the complexity of the information required and recorded. We were told that there was work ongoing with the information technology team to transfer the pathway onto the electronic system.

The storage of paper based documentation varied on the different wards. We observed on Aspull ward that they were stored in record trolleys which were contained within each bay. The trolleys were lockable and nursing staff assigned to that bay held the keys. We saw that all the trolleys on the wards we visited were locked and secured. However, on Langtree ward we found that patients who were in side rooms had their paper records which contained confidential patient information stored on clipboards outside of their rooms. These were facing outwards and were therefore visible to anyone passing.

Patient case notes which were paper based were stored in the doctors' office on the majority of wards we visited. We observed that the offices in each area were not locked during the day, but were often located behind the nurses station and could be secured. However, the doctor's office on Aspull ward did not have the ability to be locked and secured and we were told that case notes would be left in the room overnight. There was a risk that there could be unauthorised access to patients records.

In the maxillo facial surgery department, we found patient identifiable information was kept in the cupboards within some of the treatment rooms. We found that the cupboards were unlocked and

did not have the ability to be secured. Some information found in the cupboards dated back to 2010. We raised this at the time of our inspection.

We reviewed 20 patient records across all areas we visited. We saw that in the main records were consistently completed and up to date. We saw evidence that referrals had been made to other specialities when patients were scoring as at risk on risk assessments. Examples of referrals were to dieticians and speech and language therapy.

There were monthly record audits to ensure that staff were completing records to the required standard and undertaking the appropriate assessments and re-assessments as necessary. Langtree ward was 100% compliant for fluid balance and hourly rounding for the last three months.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. However, actions from an estates and facilities alert were not implemented and monitored.

Incidents were raised on an electronic system which staff had access to via the trust's intranet. Staff could include their email address if they wanted feedback on the investigation outcome of an incident they had raised. Staff we spoke with were aware of how to raise an incident.

Staff we spoke with were aware of recent incidents and learning from incidents. In theatres we were given an example of a recent incident which had been reported as a never event due to a retained guidewire. Although the investigation process was still ongoing, staff could describe the changes in practice which had been made as a result, which we were told was the addition of the guidewire to the counting out procedures. Staff told us that the learning had been shared across the trust. Staff told us there were different ways that learning from incidents was shared to ensure it captured all staff this included staff meetings, handovers, safety huddles and governance reports which were available in hard copy and via email.

There was a monthly divisional governance report which was circulated to all departments and staff. The report looked at incidents complaints, risk register and health and safety. During our inspection we observed that the report was available to staff as a paper copy in the main theatres.

In the theatres department we saw that the number of incidents reported within the month was displayed on the governance board in staff areas.

The service held monthly mortality and morbidity meetings some of which were linked to each of the outcome audits an example of this was the hip fracture audit. The upper limb service had a fortnightly mortality and morbidity meeting which we were told were mandatory for medical staff working in that speciality to attend. All of the meetings had a multidisciplinary approach and we were told that there were representatives from the nursing, medical and therapy teams. The meetings had a learning approach and the junior doctors presented the cases. The meeting minutes were shared with relevant staff so those who could not attend were informed.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust reported four incidents which were classified as never events for surgery;

- August 2018: Wrong site surgery (Royal Albert Edward Infirmary): Incorrect teeth removed.

- September 2018 (Wrightington Hospital): Wrong site surgery: Anaesthetic injected to incorrect hip.

- October 2018 (Royal Albert Edward Infirmary): Retained foreign object post procedure: Small piece of Durofibre left in situ following procedure

- December 2018 (Wrightington hospital): Wrong prosthesis: Wrong size prosthesis fitted during hip replacement.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from August 2018 to July 2019.

A breakdown of incidents by incident type is below:

- Five surgical/invasive procedures incident meeting SI criteria
- Three diagnostic incidents including delay meeting SI criteria (including failure to act on test results)
- Two sub-optimal care of the deteriorating patient meeting SI criteria
- One major incident/ emergency preparedness, resilience and response/ suspension of services
- One HCAI/Infection control incident meeting SI criteria
- One treatment delay meeting SI criteria
- One pressure ulcer meeting SI criteria
- One medication incident meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

Staff understood their responsibilities under duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Safety thermometer

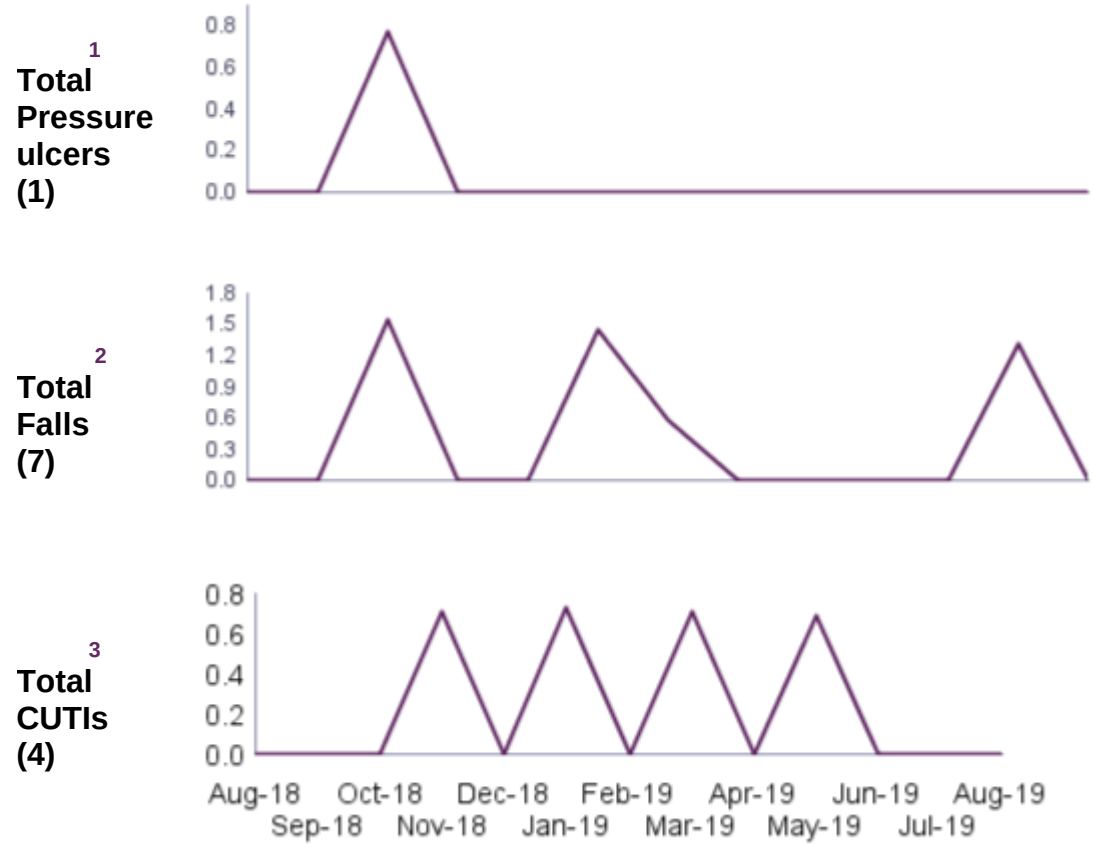
The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, seven falls with harm and four new catheter urinary tract infections from August 2018 to August 2019 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Wrightington, Wigan and Leigh NHS Foundation Trust



1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Safety thermometer information was displayed on the entrance to each ward we visited this included patient falls, hospital acquired pressure ulcers, MRSA and C-Diff data. We saw that in the main the results were positive. For example, information displayed on Swinley ward at the time of our inspection showed that there had been no falls since April 2019 and no pressure areas since August 2018. Staff were proud of their harm free care results and focussed on maintaining performance and striving to make improvements.

Is the service effective?

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Care and treatment was based on national guidelines including National Institute for Health and Care Excellence (NICE) guidelines. The service had designed a number of clinical pathways which were comprehensive and gave clear guidance for staff to follow. Examples of pathways used for different conditions, included cataract surgery, breast surgery, hip fracture and prostate surgery.

The hip fracture pathway followed national guidance and the service design reflected this. Patients on this pathway were reviewed daily by an Orthogeriatrican and there were two beds which were ring fenced for hip fracture trauma patients. The service reported the patient outcomes for hip fractures to the national audit database and we were told that the service was in the top 10% highest performing trusts nationally.

Guidelines, policies and standard operating procedures we saw were up to date and reviewed regularly to implement new guidance. The surgery divisional governance report for September 2019 noted there were ten NICE guidelines awaiting nomination or completion. Information about any updates were shared in safety huddles, handovers and ward meetings.

Policies and procedures were available on the trust intranet page for all staff, making them easily accessible. Policies appropriately referenced current good practice and national guidelines and documents contained clear guidance, referral flow charts, escalation pathways and other information.

Preoperative assessments and admission documentation took a holistic approach to assessing patients' needs. We saw that these took account of physical health, social needs, mental health and likes and dislikes.

The service participated in the trust's audit programme, with audits compared to recognised standards and guidelines both internally and nationally. Various local audits were completed in different services.

The service used nationally recognised principles for Getting It Right First Time (GIRFT), which is a national programme to improve consistency. As a result, the senior medical team described positive results. We were told that there had been a collaborative approach for trauma patients and the results were consistent for lower limb services. The service reported it was a positive outlier for hip replacement and were able to do these at a low cost. For upper limb services as a result of the outcomes there had been changes to the elbow surgery services which had resulted in two specialist consultant posts being made available to centralise the service and improve outcomes.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs. Staff followed national

guidelines to make sure patients fasting before surgery were not without food for long periods.

The service used a malnutrition universal screening tool to assess patient's nutritional requirements. The electronic system prompted staff to complete these and performance was monitored on a monthly basis. We saw that assessments were consistently completed and referrals to dieticians and speech and language therapy had been made as a result of the scores.

Patients were reviewed by the dietician team if they had been identified as at risk of malnutrition or malnourished. Referrals were made via the electronic system and staff also had access to a bleep number for the team and that they often responded promptly.

There was a specialist nutrition nurse for the service. In addition, there were weekly nutrition rounds where high risk patients were reviewed.

We reviewed 20 patients records and we saw that fluid balance charts were consistently completed for all patients. Patients who had been identified as at risk of malnutrition or identified as malnourished had been initiated on food records and weighing charts. We saw that these had been consistently completed and re-assessments completed as necessary.

Each ward had protected meal times which were displayed on the entrance. We saw that on each ward where these were displayed there was a note to the families which stated if they wished to support their loved one to eat to discuss this with the nurse in charge. During our observations of meal times we observed staff assisting patients to eat their meals.

The trauma co-ordinators had worked closely with the orthogeriatrician and the dietetics team to ensure that all patients who presented on the fractured neck of femur pathway, promptly had their swallowing and nutritional needs assessments completed. There had been an agreement about the initiation of nutritional products and iron infusions for patients on the pathway identified as at risk of malnutrition, it had been identified that this aided the recovery of the patient group. We were told at the time of our inspection that the regimes had not been added to the pathway, however this had been identified as a development for the future.

Notice boards above patients beds indicated their special dietary requirements.

The service used a colour coded jug system to identify patients who had additional needs and may require assistance with drinking or may need to be prompted to have a drink.

Patients commented that they enjoyed the food and indicated that there were many options to meet their needs. One patient described the food as 'belting'.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The service used a nationally recognised scoring system to identify the level of pain patients were in. Patients who were unable to communicate verbally or had additional needs had their pain assessed using physical and behavioural prompts to identify patients pain needs.

We observed staff in all areas asking patients about their pain. We saw positive interactions when discussing pain and saw that staff discussed patient's medicine options with them. In theatre recovery we observed staff assessing patients' pain and documenting the appropriate pain scores.

Patients we spoke with told us they had their pain regularly assessed and they were given pain relief when they needed it.

Swinley Ward had recently identified a concern with the recording of pain assessments and use of patient controlled analgesia. The specialist pain nurse for the service worked closely with staff to make improvements and re-audits demonstrated positive results.

The maxillo facial surgery department held a facial pain clinic on a bi-weekly basis. The pain clinic provided patients with chronic facial pain injections into the nerve to help manage their pain.

Patient outcomes

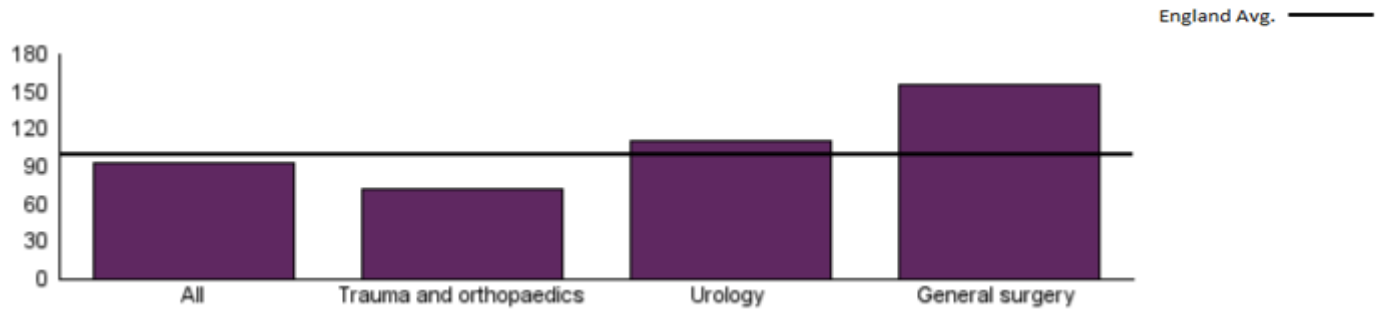
Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Relative risk of readmission

Trust level

From February 2018 to January 2019, all patients at the trust had a lower than expected risk of readmission for elective and non-elective admissions when compared to the England average.

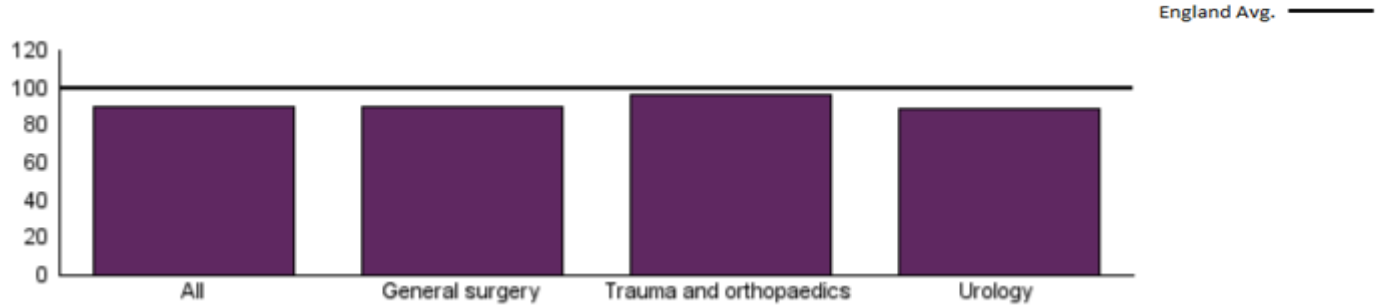
Elective Admissions – Trust Level



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in trauma and orthopaedics had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Patients in urology and general surgery had a higher than expected risk of readmission for elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level



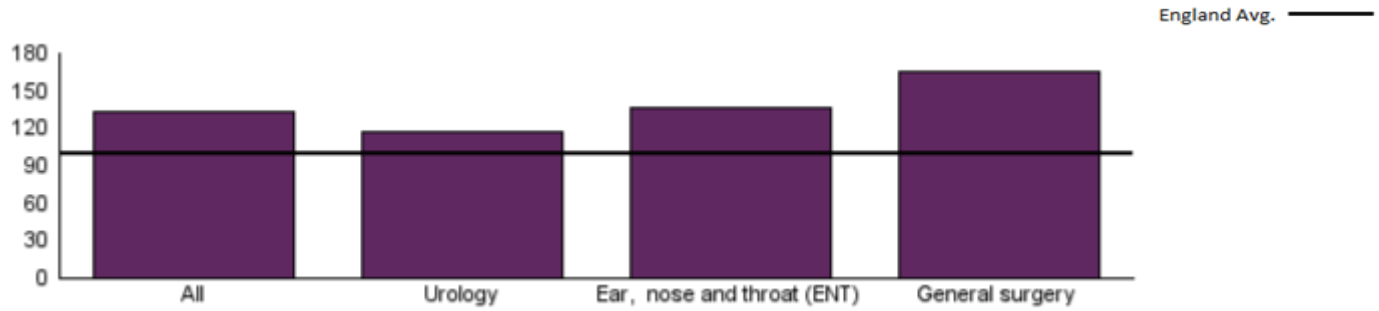
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in general surgery, trauma and orthopaedics and urology had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Royal Albert Edward Infirmary

From February 2018 to January 2019, all patients at the Royal Albert Edward Infirmary had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

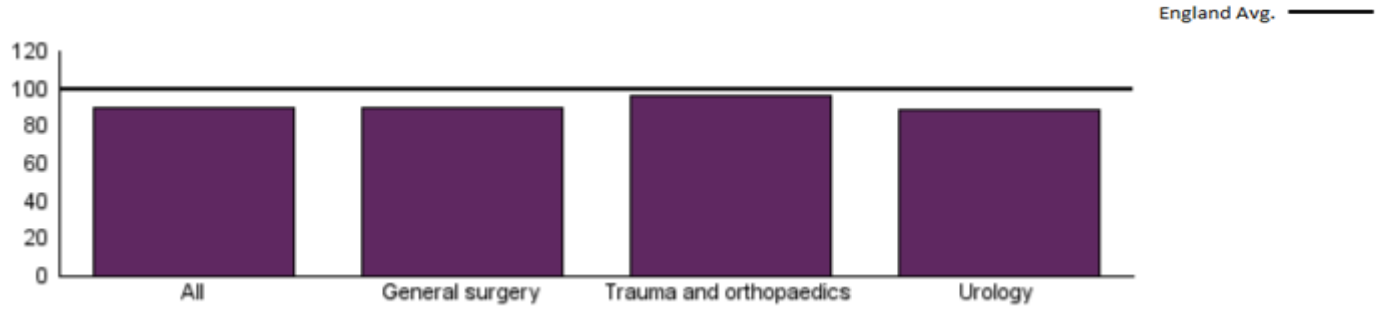
Elective Admissions - Royal Albert Edward Infirmary



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity

- Patients in urology, ENT and general surgery at RAEI had a higher than expected risk of readmission for elective admissions when compared to the England average.

Non-Elective Admissions - Royal Albert Edward Infirmary



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity

- Patients in general surgery, trauma and orthopaedics and urology at RAEI had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

(Source: Hospital Episode Statistics - HES - Readmissions (01/02/2018 - 31/01/2019))

National Hip Fracture Database

Royal Albert Edward Infirmary

The table below summarises Royal Albert Edward Infirmary's performance in the 2018 National Hip Fracture Database.

For five measures, the audit reports performance in quartiles. In this context, 'similar' means that the trust's performance fell within the middle 50% of results nationally.

Metrics *(Audit indicators)*	Hospital performance	Comparison to other Trusts	Met national standard?
Case ascertainment* *(Proportion of eligible cases included in the audit)*	109.3%	Better	Met
Crude proportion of patients having surgery on the day or day after admission *(It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)*	80.3%	Better	Did not meet
Crude peri-operative medical assessment rate *(NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome*)	96.6%	Similar	Did not meet
Crude proportion of patients documented as not developing a pressure ulcer *(Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient's admission); this measures an organisation's ability to report 'documented as no pressure ulcer' for a patient*	99.4%	Better	Did not meet
Crude overall hospital length of stay *(A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)*	13.8 days	Better	No current standard
Risk-adjusted 30-day mortality rate *(Adjusted scores take into account the differences in the case-mix of patients treated)*	8.8%	Within expected range	No current standard

* This metric shows the proportion of eligible cases within the hospital that were submitted to the audit. The comparison is made against Hospital Episode Statistics data. This can sometimes be higher than 100% due to inconsistencies in local coding methodologies.

(Source: National Hip Fracture Database)

Bowel Cancer Audit

The table below summarises the trust's performance in the 2018 National Bowel Cancer Audit.

Metrics *(Audit measures)*	Trust performance	Comparison to other Trusts	Met national standard?
Case ascertainment *(Proportion of eligible cases included in the audit)*	94.9%	Good	Good is over 80%
Risk-adjusted post-operative length of stay >5 days after major resection	53.5%	Better than national aggregate	No current standard

(A prolonged length of stay can pose risks to patients)			
Risk-adjusted 90-day post-operative mortality rate *(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure*)	2.2%	Within expected range	No current standard
Risk-adjusted 2-year post-operative mortality rate *(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy*)	19.1%	Within expected range	No current standard
Risk-adjusted 30-day unplanned readmission rate *(A potential risk for early/inappropriate discharge is the need for unplanned readmission)*	8.0%	Within expected range	No current standard
Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection *(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases, it will not, and a temporary stoma would be created. For some procedures this can be reversed at a later date)*	40.5%	Within expected range	No current standard

(Source: National Bowel Cancer Audit)

National Oesophago-gastric Cancer Audit

(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)

The table below summarises the trust's performance in the 2018 National Oesophago-gastric Cancer Audit.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other Trusts**	**Met national standard?**
Trust-level metrics *(Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)*			
Case ascertainment *(Proportion of eligible cases included in the audit)*	81.0-90%	Better	No current standard
Age and sex adjusted proportion of patients diagnosed after an emergency admission *(Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)*	6.1%	Better	No current standard
Risk adjusted 90-day post-operative mortality	Not eligible	Not eligible	No current

rate *(Proportion of patients who die within 90 days of their operation*)			standard
Cancer Alliance level metrics *(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.*			
Crude proportion of patients treated with curative intent in the Cancer Alliance *(Proportion of patients receiving treatment intended to cure their cancer)*	35.4%	Significantly lower than the national aggregate	No current standard

(Source: National Oesophago-Gastric Cancer Audit)

National Emergency Laparotomy Audit

Royal Albert Edward Infirmary

The table below summarises Royal Albert Edward Infirmary's performance in the 2017 National Emergency Laparotomy Audit.

The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard.

Metrics ***(Audit measures)***	**Hospital performance**	**Audit's Rating**	**Met national standard?**
Case ascertainment *(Proportion of eligible cases included in the audit)*	90%	Green	Met
Crude proportion of cases with pre-operative documentation of risk of death *(Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)*	94%	Green	Met
Crude proportion of cases with access to theatres within clinically appropriate time frames *(Proportion of patients who were operated on within recommended times*)	89%	Green	Met
Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre *(Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)*	76%	Amber	Did not meet
Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively (*Proportion of patients with a high risk of death*	82%	Amber	Did not meet

(10% or more) who are admitted to a Critical/Intensive Care ward after their operation)			
Risk-adjusted 30-day mortality rate *(Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)*	6%	Within expected range	No current standard

(Source: National Emergency Laparotomy Audit)

The senior leadership team were proud of their performance in this audit. At the time of our inspection they stated that the last quarter results demonstrated that they achieved 92% which they said was the highest outcome in Greater Manchester.

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The table below summarises the trust's performance in the 2018 National Ophthalmology Database Audit.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other Trusts**	**Met national standard?**
Trust-level metrics *(Measures of hospital performance in the treatment of cataracts*			
Case ascertainment *(Proportion of eligible cases included in the audit)*	98.4%	n/a	No current standard
Risk-adjusted posterior capsule rupture rate *(Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.*	0.8%	Within expected range	No current standard
Risk adjusted visual acuity loss *(The most important outcome following cataract surgery is the clarity of vision*)	0.5%	Within expected range	No current standard

(Source: National Ophthalmology Database Audit)

National Prostate Cancer Audit

The table below summarises the trust's performance in the 2018 National Prostate Cancer Audit.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other trusts**	**Met national standard?**
Men with complete information to determine disease status *(This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)*	97.0%	N/A	Did not meet

Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy *(A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)*	No data available	No data available	No current standard
Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy *(Complications following surgery may reflect the quality of surgical care*)	No data available	No data available	No current standard
Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy *(External beam radiotherapy uses high-energy beams to destroy cancer cells)*	No data available	No data available	No current standard

(Source: National Prostate Cancer Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

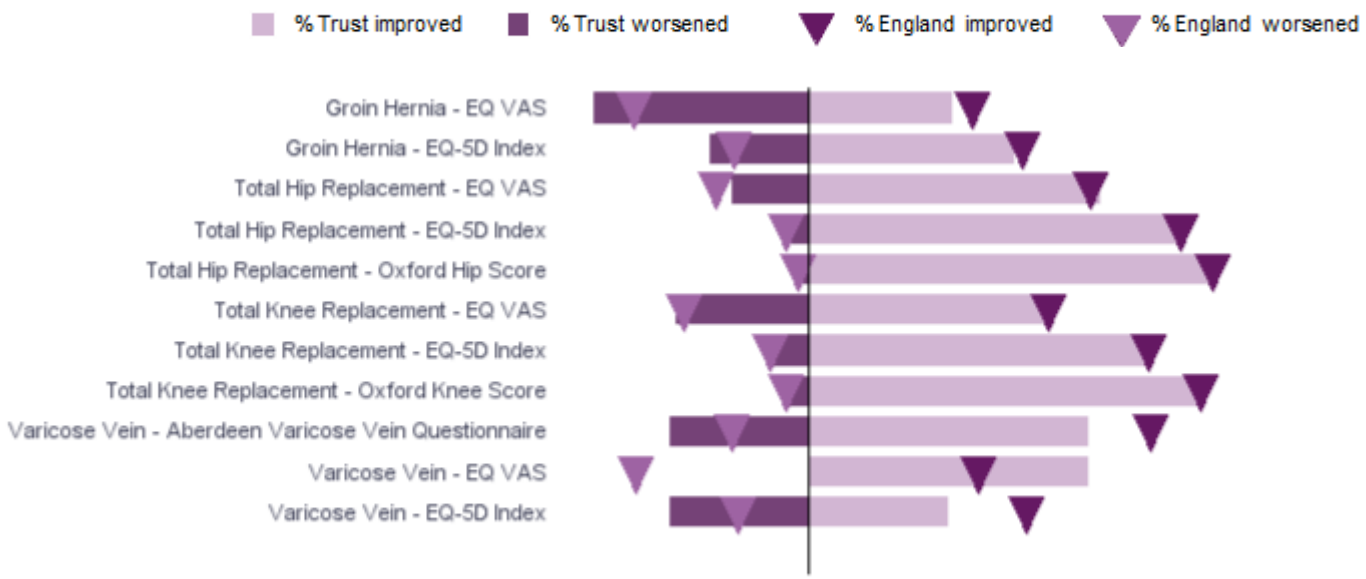
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

Visual analogue scale (EQ-VAS)

Visual analogue scale (EQ VAS) is, asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific Issues namely mobility self-care usual activities pain or discomfort anxiety or depression. The EQ-5D-5L uses 5 levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.



In 2016/17 performance on groin hernias was worse than the England average for EQ VAS and EQ-5D index.
For Varicose Veins, performance was worse than the England average for Aberdeen Varicose Vein Questionnaire and EQ-5D index, but for varicose vein EQ VAS trust performance was better than the England average.

For hip replacements, performance was about the same as the England average for all three measures.

For knee replacements was about the same as the England average for all three measures.

(Source: NHS Digital)

The service held monthly divisional audit meetings. The meetings reviewed patient outcomes and identified areas for improvement. We were told that information was cascaded with staff from the meeting through email and through consultant teaching sessions.

We were told that the main challenge was getting to patients on the hip fracture pathway into theatre within the 36 hour time frame. Initially it had been identified the reason was due to the number of orthopaedic surgeons being available. The service had recruited three additional orthopaedic surgeons to the service in response. It had been identified that there was still a number of patients not meeting the 36 hour target it was recognised this was due to patients being on anticoagulants and so they had to stop these and wait a period of time until it was safe for them to have surgery. We were told that this was an area the service was now looking into.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, the service did not meet the trust's target for appraisal compliance.

Nursing and medical staff we spoke with told us that they had received an induction and relevant training. There were induction and competency processes which met with the requirements of the role staff were in and provided a structured approach.

Ward support staff were given a two-week supernumerary period which included a corporate induction and the implementation of an externally accredited care training course. Support staff were given a buddy to support them through the process and their assessments and sign off were overseen by the ward manager. Nurses received a supernumerary period of two to six weeks dependant on their experience and competence. This included a two week clinical induction where they received the initial sign off for a number of competencies which were undertaken in the skills laboratory in the hospital's education centre. The final sign off of nursing competencies was undertaken by their ward manager.

We spoke with a support staff member who spoke highly of the induction process and the externally accredited care course. They felt that the induction process and training was comprehensive.

There was a comprehensive list of competencies which were relevant to the role staff were undertaking. This included areas such as blood transfusion, enhanced recovery, health and safety and medicines administration. A practice education facilitator was available to support surgery staff, working across the trust's three hospital sites. Managers monitored staffs training compliance. We requested training compliance figures for three of the wards we visited however we were not provided with this information.

The theatres department ensured that all scrub staff were appropriately qualified and at the time of our inspection they reported that there were three staff who were undertaking their qualification. The service was looking into development opportunities to develop the band four workforce to work in the scrub department, they were working closely with the corporate training and development team to develop a robust training programme.

The wards and theatres had link nurse roles which were available to nursing and support staff who had a particular interest or additional training in a certain area. Link nurse roles included for moving and handling, tissue viability, infection prevention and control, alcohol, pain, dementia and sepsis. These staff members received additional specialist training for their role which they cascaded to staff in their area. They also attend regular meetings led by the trust lead for their field of expertise to share experience, keep up to date with guidance and best practice and develop any support materials for staff.

Trauma and orthopaedics training was provided by the senior nurse for trauma and orthopaedics at Wrightington Hospital. The nurse provided training sessions at both sites so staff had the same knowledge and skills and could work competently at both sites when cross cover was required.

Appraisal rates

Trust level

From April 2018 to March 2019, 83.5% of required staff in surgery at trust level received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the tables below:

Staff group	Staff who received appraisal	Eligible staff	Completion rate	Trust Target	Met (Yes/No)
Administrative and clerical	96	109	88.1%	90%	No

Allied health professionals	56	66	84.8%	90%	No
Nursing and midwifery registered	308	365	84.4%	90%	No
Healthcare scientists	10	12	83.3%	90%	No
Additional clinical services	223	273	81.7%	90%	No
Add prof scientific and technic	33	44	75.0%	90%	No

Royal Albert Edward Infirmary

From April 2018 to March 2019, 82.7% of required staff in surgery at the Royal Albert Edward Infirmary received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the tables below:

Staff group	Staff who received appraisal	Eligible staff	Completion rate	Trust Target	Met (Yes/No)
Administrative and clerical	49	54	90.7%	90%	Yes
Add prof scientific and technic	16	19	84.2%	90%	No
Nursing and midwifery registered	132	161	82.0%	90%	No
Allied health professionals	9	11	81.8%	90%	No
Additional clinical services	96	119	80.7%	90%	No
Healthcare scientists	0	1	0.0%	90%	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Staff we spoke with told us they had received a recent appraisal and identified that they felt they were a positive process and beneficial. Staff described how they had identified areas for further development and how their line managers had supported them with this. Staff told us they were supported to attended internal and external courses to expand their knowledge and we were told about a member of nursing staff would be attending a certifying death course so that they could certify expected deaths.

There were band five nurses who undertook the 'senior nurse walk around' during the weekends. Staff felt that this provided an opportunity to step up and enabled them to undertake some problem solving for minor issues.

The maxillofacial service provided a training programme to student dental nurses which was accredited by an external exam board. The course covered a range of maxillo facial surgery topics such as orthodontics, maxillo facial surgery, biopsies, trauma and oncology. The training met with national standards and it was monitored and reviewed by the exam board. The sister for the service was the lead for the training, we were told that they had been accredited for eight years and re-accreditation was every three years.

Multidisciplinary working

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

The nursing team and medical team were supported by a multidisciplinary team consisting of physiotherapists, speech and language therapists, occupational therapists, pharmacists and pharmacy technicians, social workers and dieticians. Staff described good relationships with the multidisciplinary teams, they described a positive and supportive approach to patient care. During our observations we saw that there were positive interactions between the multidisciplinary team.

We observed positive discussions which demonstrated good team working and a collective approach to patient care.

The allied health professional team provided a service to a number of wards. Patients were therefore reviewed on a referral basis. Staff could refer patients using the electronic system and we saw evidence of this during our observations of patient records. The multidisciplinary team attended the ward rounds to assist in identifying patients who needed their input.

The physiotherapy team told us that the majority of patients that they saw were patients who had been stepped down from the critical care unit and required chest physiotherapy, orthopaedic patients and medical outliers. We were told that there was a strong and close working relationship between the physiotherapy and occupational therapy teams, but also with their wider ward teams.

There were daily trauma meetings which had multidisciplinary attendance and a weekly multidisciplinary team meeting for patients who were on the hip fracture pathway. The meetings included the trauma co-ordinators, nurses, the Orthogeriatrican, physiotherapy and occupational therapy.

In addition, patients with complex needs or discharges were reviewed on an as needed basis by the multidisciplinary team. This sometimes included the district nurse liaison team who would pick up referrals to the community.

Patients who were on the cancer lists had their care discussed in multidisciplinary meetings ahead of their admission to the service. When patients who had cancer were admitted to the unit there were additional weekly multidisciplinary team meetings to discuss their care, these included the specialist nurses and oncology specialists.

There was a monthly trauma strategy and clinical meeting which had representation from the multidisciplinary team. These included trauma co-ordinators, medical staff, physiotherapists, ward managers and business leads. The meetings reviewed the hip fracture database and patients who had been admitted but did not meet the requirements of the best practice pathways were discussed, to identify themes and trends in order to make improvements for the future.

Stoma specialist nurses attended Swinley Ward on a daily basis to review patients under their care.

Seven-day services

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

The theatres department operated twenty four hours per day seven days a week for emergency surgeries.

The trauma team operated a seven day service to ensure that patients were treated in a timely manner on the appropriate pathways.

The orthogeriatrician team were unable to provide a seven day service to trauma patients which was not in line with best practice, this was due to vacancies in the team. Patients were however reviewed by the trauma medical team and the trauma co-ordinator's to ensure the appropriate pathway was initiated.

The pre-operative assessment team operated Monday to Friday 8.50am to 4.50pm. We were told that following a recent patient survey about the opening hours, the service was reviewing the hours of work and hoped to provide evening appointments in the future up to 6.30pm.

The drug and alcohol team were available seven days a week during working hours. Patients were referred by a bleep system and were seen promptly. We saw this during our observations.

Physiotherapy provided services to the wards Monday to Friday. Outside of working hours they could be contacted on call for respiratory physiotherapy.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

There was an enhanced recovery nurse assigned to the gynaecology service. The nurse identified patients who would be eligible for the enhanced recovery service during the pre-operative assessment. These patients were followed through their journey on the ward which involved a follow up day one post-operatively. The nurse provided the patient and the nurses who were in charge of their care a clear plan with goals to speed up their recovery and aid early discharge.

The service provided a fracture liaison service. Patients who presented with fragility fractures were seen as outpatients. The clinics looked at their bone health and treatment and advice given to help maintain and improve their bone health.

Patients who had been admitted on the fractured neck of femur pathway were followed up by the trauma co-ordinator teams 30 days after their surgery. The initial follow up aimed to identify any issues or concerns and the appropriate onward referrals were made such as to physiotherapy. In addition, the patient's bone health was reviewed, and protection medicine initiated where necessary. Patients received a second follow up 120 days post surgery to review their mobility and bone health.

During the pre-operative assessment process patients who were identified as smokers were offered an additional service which included carbon monoxide testing. In addition, patients who smoked were offered smoking cessation services.

Staff had access to a drug and alcohol team where patients could be referred to if there were concerns about their lifestyle. The pre-operative assessment team encouraged referrals into the service. The team was available seven days a week during working hours and staff described good access to them if they required it.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Consent for surgical procedures was often obtained in the clinics prior to admission and documented in the paper records. General surgery admissions were often consented on the day of surgery in the surgical admissions lounge as part of the admission process.

Theatre staff spoke with patients prior to their surgery to ensure they were aware of what surgery they were having, the intended outcomes and any risk factors. We observed this process with one patient we saw that the member of staff checked the patient's name, date of birth, allergy status and past medical history. They asked the patient to confirm their expected procedure and discussed this with them, they allowed the patient to share any concerns that they had and these were discussed. We observed that the discussion was documented by the staff member in the patient's care plan.

Patients we spoke with described the consent process and indicated that this was gone through again following their admission.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

There was a process in place for the assessment of patient's capacity to consent and an escalation process if staff had assessed someone as lacking capacity. We saw that there was documentation in use which staff completed the assessment on, it guided them through the process and identified actions dependant on the outcome.

Staff we spoke with felt competent in the assessment and identification of patients who lacked capacity or may require a deprivation of liberty safeguard. Staff were aware of the process to follow and could explain it to us and knew where to access support such as the safeguarding team for the trust.

We reviewed deprivation of liberty safeguard documentation and mental capacity assessments for three patients. We observed that the documentation had been completed and reviewed within the relevant timescales. We observed documentation which demonstrated regular reviews and involvement from the safeguarding team.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Trust level

The trust set a target of 95% for the completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training modules from April 2018 to March 2019 at trust level for qualified nursing staff in surgery is shown below:

In surgery the target was not met for either of the two Mental Capacity Act training modules for which qualified nursing staff were eligible.

Training module name	April 2018 to March 2019				
	Staff trained /compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	424	455	93.2%	95%	No

A breakdown of compliance for MCA training from April 2018 to March 2019 at trust level for medical staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	95	163	58.3%	95%	No

Royal Albert Edward Infirmary

A breakdown of compliance for MCA training modules from April 2018 to March 2019 for qualified nursing staff in surgery at the Royal Albert Edward Infirmary is shown below:

In surgery the target was not met for either of the two Mental Capacity Act training modules for which qualified nursing staff at the Royal Albert Edward Infirmary were eligible.

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	324	352	92.0%	95%	No

A breakdown of compliance for MCA training module from April 2018 to March 2019 for medical staff in surgery at the Royal Albert Edward Infirmary is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	92	95	96.84%	95%	Yes

Wards and theatres had nominated champions for Mental Capacity, Mental Health Act and deprivation of liberty safeguards. These staff members received additional training and attended a monthly meeting to review how their area was performing and identified areas for improvement. We saw in the theatres department a noticeboard with information for staff about mental capacity and mental wellbeing.

Is the service caring?

Compassionate care

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

We saw that all grades of staff treated patients with care and compassion. We observed a member of domestic staff who recognised a patient was cold and offered to get them a blanket. Staff we spoke with explained that they treated all patients in the way they would like themselves or their families to be treated.

Patients were continually positive about the care they received. We were told that “the nursing and medical staff are pleasant”, “staff are always friendly” On the wards we visited we observed thank you cards from patients displayed in public areas we saw that they read “thanks to an all-star team”, “thank you to all of you who have shown care, kindness and love not only to mum but to all her family and visitors”,

Patients felt that staff were attentive to their needs. Patients told us staff promptly responded to the call bells and provided assistance for personal care. We saw that call bells were answered promptly, and staff treated patients with kindness and discretion.

Patients felt that their privacy and dignity was always maintained. We saw on medical ward rounds that the teams were aware of the need to maintain patients’ privacy and dignity particularly in the large bays. We saw that the medical team pulled the curtains round when discussing patients care with them and we observed that they spoke quietly so others in the bay could not easily hear.

The trust had implemented an initiative called ‘always events’, this had been implemented in 2016 and was an embedded practice. There were ten always events and in the main they related to how staff should provide care to patients. We saw that these included addressing patients by their preferred name, staff will always introduce themselves to patients, always show patients and their families a level of respect they would expect themselves, keep patients and their families informed about their care in a way they understand and to continue to provide dignified care to patients who have died. We saw that the always events were well publicised and there were cards available to patients which told them what they were and what they should expect from their care.

Performance for friends and family tests and the ten always events was monitored and recorded on a monthly basis. We saw that the results were displayed on the entrance to each ward we visited. At the time of our inspection we saw that the results were displayed for September 2019 in the main the results were positive and were between 91.4% and 100%.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Admission and pre-operative assessment documentation took account of patients holistic needs which included their personal, cultural and religious needs. This meant that staff could be receptive and responsive to their needs and identify any additional support patients may require.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed theatre staff providing reassurance and support to a patient who was anxious prior to surgery. They allowed the patient to ask any questions and there was an in-depth discussion about their procedure and any questions the patient had were answered.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff were sensitive to the emotional needs of patients undergoing investigations. They took time to support patients when they were upset.

Understanding and involvement of patients and those close to them

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

All patients we spoke with told us that all staff introduced themselves by name.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients were aware of how to raise a concern if they needed to and told us they would feel comfortable in doing so.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with felt that staff involved them and their families in their care and treatment. We spoke with a patient who was awaiting surgery they told us they had received a full explanation of their procedure, whilst they were on the ward they had been visited by the aftercare team to discuss their recovery which involved taking into consideration their home and personal circumstances.

Is the service responsive?

Service delivery to meet the needs of local people

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

However, the waiting area for the maxillo facial surgery department did not always provide enough space to accommodate the number of patients attending clinics and made it difficult for patients in wheelchairs to access.

Service leaders were aware of their local population. The specialist services division were clear that their main aim was to provide services for the local population which included simple services to meet the needs of the people who lived in the local area. In addition, they also provided more complex innovative orthopaedic services which served the wider population of Greater Manchester, South Cumbria and Lancashire.

The service worked closely with local and regional commissioning groups to plan and develop services. There were plans to work with other trusts as one centre so that one hospital would provide services for elective admissions and the other would provide urgent.

Each ward had set visiting times which were displayed in the entrance, in addition it was identified for visitors to contact the nurse in charge if they wished to visit outside of these hours.

We observed a range of leaflets available on the wards for patients and their families these included information about sepsis and the sepsis six pathway, planning your future care and a range of leaflets from specialist support services and charities for specific conditions.

The pre-operative assessment service had recently undertaken a patient survey about their opening hours. As a result, the service was looking to provide later clinics until 6.30 pm to accommodate patients who required a later appointment.

The trust worked in collaboration with a local council initiative to provide support for patients over the age of 50 living in Wigan living alone who were being discharged. The service could make referrals to 'Wigan and Leigh Pensioners Link' for patients to receive a free transport service and a welcome home bag of basic food items.

The surgical admissions lounge had a main waiting area where patients waited to be booked in for their procedure, once patients had been booked in there were separate male and female waiting rooms. The department also had three side rooms for patients who required additional space or more privacy, this included patients with learning difficulties, patients living with dementia, patients who were accompanied by carers or young adults accompanied by their families.

The maxillo facial surgery department had identified that the department was aging and required some expansion to support the services delivered. It had been identified that the consultation rooms did not always provide adequate privacy due to the layout and construction and the waiting room was not always big enough to accommodate the number of patients attending clinics, particularly for those requiring wheelchair access. We observed the area during a busy clinic and saw that patients had to stand on the corridor as there was not enough seating as did some patients in wheelchairs as access was reduced. We were told that work was ongoing to identify appropriate accommodation for the service

Meeting people's individual needs

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

The trust had implemented 'always events' these were 10 principles for ensuring that patients' needs were met, and staff treated patients as individuals. We saw that in theatres the always events were on display and we were told that the service had a focus on a different event on a weekly basis. The always events were audited on a monthly basis through observations and we saw that departments displayed their most recent results. In the main results were positive.

Each ward had a number of different link nurses who had an interest and additional training in certain areas. We saw that there were link nurses for learning disabilities, dementia, alcohol and deprivation of liberty safeguards. These staff cascaded training and information to the ward team and were there to support those looking after patients with additional needs. On Aspull Ward we saw that a dementia information board had been introduced, it provided information about the different types of dementia and provided contact details for local dementia charities and dementia cafes.

Pre-operative assessments were completed on the electronic system and took a holistic approach to patients care and needs ahead of their surgery. If patients were identified as having additional needs in the pre-operative clinic, staff told us they would work with family and carers to identify the patient's needs when they are admitted for their surgery and formulate a plan prior to their admission to make sure that the required support arrangements were in place. Wards explained how they worked closely with the pre-operative assessment clinic to ensure that the appropriate support and staffing was in place prior to the patients' admission

We were told that the pre-operative assessment and the surgical admissions unit had worked closely with the lead nurse for learning difficulties to make sure they were focussing on patients' needs and that the service was accessible. In addition, the service had developed a video, in conjunction with a local learning disability charity, about 'going into hospital', so patients with additional needs could watch it prior to their stay and have an understanding of what to expect.

Staff described good access to resources to support patients who were living with dementia. All staff attended a two day dementia awareness course as part of their mandatory training. There was a dementia care bundle box which staff could access, and they used "this is me" booklets which had been created by a national dementia charity. The booklets enabled the patient and their family to document their likes, dislikes and care needs. In addition, patients who were identified as having dementia or additional needs were identified using a flower on the handover and patients boards so staff could easily identify those patients.

Aspull ward provided care for trauma and orthopaedic patients. We observed they had a dementia box which contained a range of games, puzzles and reminiscence books about the local area. In addition, they had a communication book which provided pictures for patients who could not communicate verbally to express their needs and feelings.

Patients who were assessed as having enhanced care needs could be supported by a support staff member from an enhanced care agency which the trust was authorised to use. The agency support staff had received additional specialist training in caring for patients who had enhanced care requirements. Patients who scored highly for their needs and were identified as requiring one to one care received support from the agency staff, senior nurses told us they were supported by

the trust to obtain the additional support and we observed patients who had the carers were settled and satisfied.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Written information was displayed in English language formats, although staff could arrange for alternative language translations where this was needed. The service had access to the trust's interpreter and translation services for patients whose first language was not English.

Ward staff could access speciality equipment for patients when they needed it. The hospital had a central loan store which was open daily until 5pm. Requests for equipment were made via the trust's intranet page and staff reported equipment was delivered in a timely manner. Outside of working hours staff had access to the central equipment loan store and could obtain the equipment they needed which was then recorded on a paper record.

We spoke with a patient who had been provided with specialist holders for their drinking cup due to limited mobility in their hands, this enabled them to remain independent whilst on the ward.

Access and flow

People could mostly access the service when they needed it and received the right care promptly. In the main the trust performed better than the national average for waiting times from referral to treatment and arrangements to admit, treat and discharge patients. However, referral to treatment times for urology, ophthalmology and general surgery fell short of the national average.

All elective admissions were pre-admitted prior to being given a date for surgery and attending the surgical admissions lounge. Patients undergoing elective surgery attended the surgical admissions lounge prior to their surgery, the admissions unit notified the ward when a patient's slot was if they were being accommodated on the wards to prevent patients waiting in the lounge for long periods.

There were three trauma co-ordinators who were attached to Aspull ward. They provided a link across the hospital for trauma patients. They attended the daily trauma multidisciplinary meetings which took place each morning, following this they attended the ward rounds and post take ward rounds with the orthogeriatrician. Their role was to co-ordinate the flow of patients on the fractured neck of femur pathway throughout the hospital to ensure that beds were available for new patients presenting in the emergency department. In addition, there were two protected trauma beds (a male and a female bed) for these patients on Aspull Ward. There was a standard operating procedure and escalation process to protect the beds so that they were not utilised for other specialities. We were told that on average one trauma patient was admitted on the fracture neck of femur pathway per day.

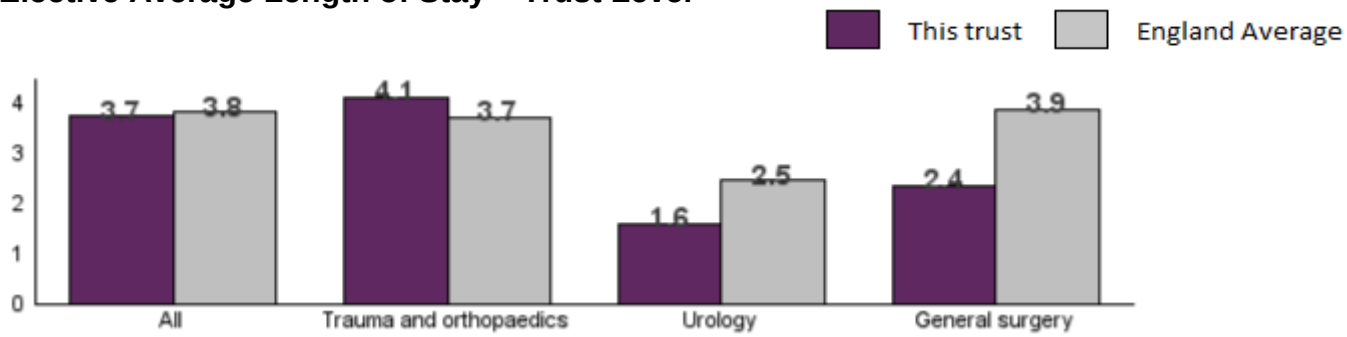
Average length of stay

Trust Level

From March 2018 to February 2019 the average length of stay for all surgical elective patients at the trust was 3.7 days which is similar to the England average of 3.8 days.

For surgical non-elective patients, the average length of stay was 4.0 days which was lower than the England average of 4.7 days.

Elective Average Length of Stay – Trust Level

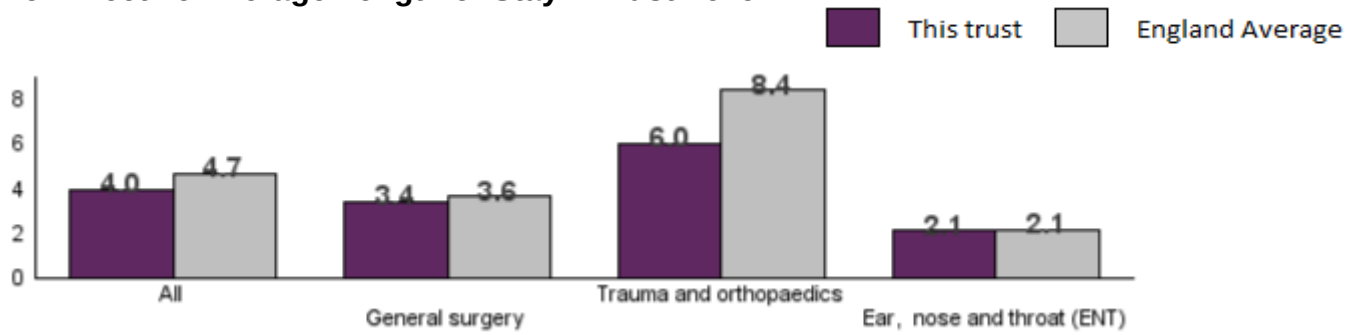


Note: Top three specialties for specific trust based on count of activity.

Average length of stay for elective specialties:

- Average length of stay for elective patients in urology and general surgery is lower than the England averages.
- Average length of stay for elective patients in trauma and orthopaedics is similar to the England average.

Non-Elective Average Length of Stay – Trust Level



Note: Top three specialties for specific trust based on count of activity.

Average length of stay for non-elective specialties:

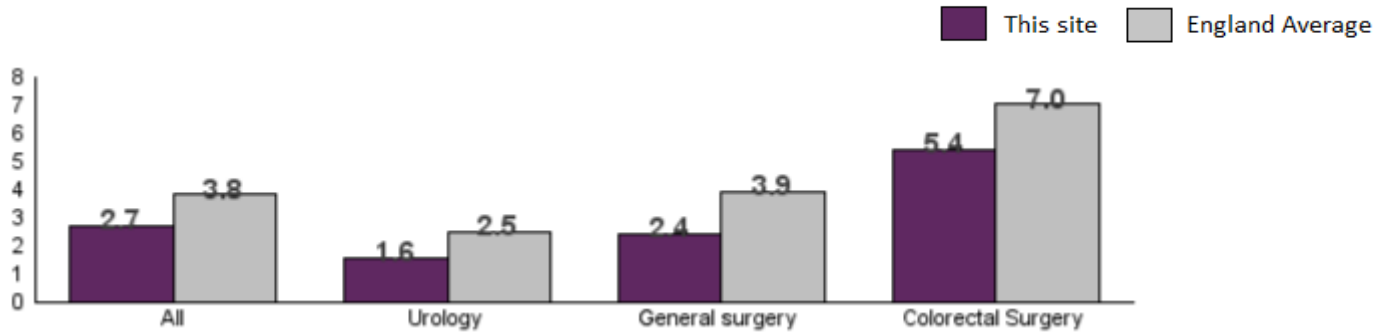
- Average length of stay for non-elective patients in trauma and orthopaedics is lower than the England average.
- Average length of stay for non-elective patients in general surgery and ENT is similar to the England averages.

Royal Albert Edward Infirmary

From March 2018 to February 2019 the average length of stay for all surgical elective patients at Royal Albert Edward Infirmary was 2.7 days, which is lower than the England average of 3.8 days.

For surgical non-elective patients, the average length of stay at Royal Albert Edward Infirmary was 3.9 days, which is lower than the England average of 4.7 days.

Elective Average Length of Stay - Royal Albert Edward Infirmary

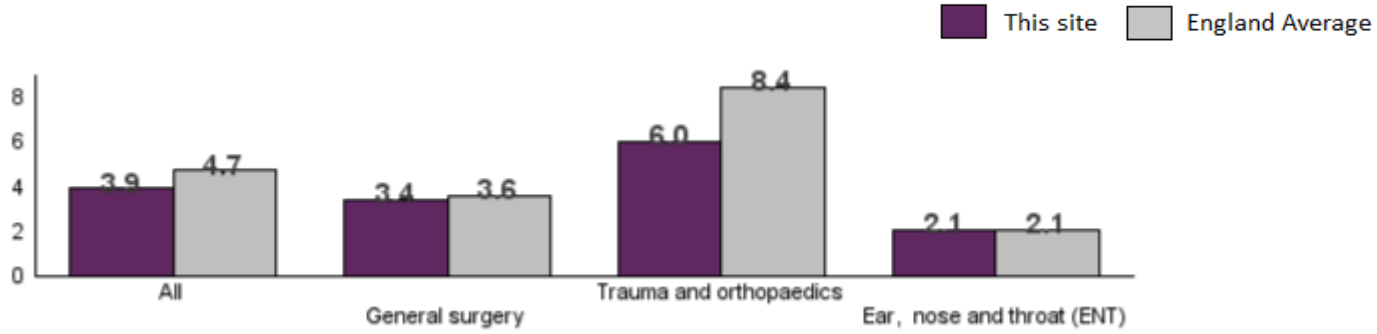


Note: Top three specialties for specific site based on count of activity.

Average length of stay for elective specialties:

- Average length of stay for elective patients in urology, general surgery and colorectal surgery is lower than the England averages.

Non-Elective Average Length of Stay - Royal Albert Edward Infirmary



Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in trauma and orthopaedics is lower than the England average.
- Average length of stay for non-elective patients in general surgery and ENT is similar to the England averages.

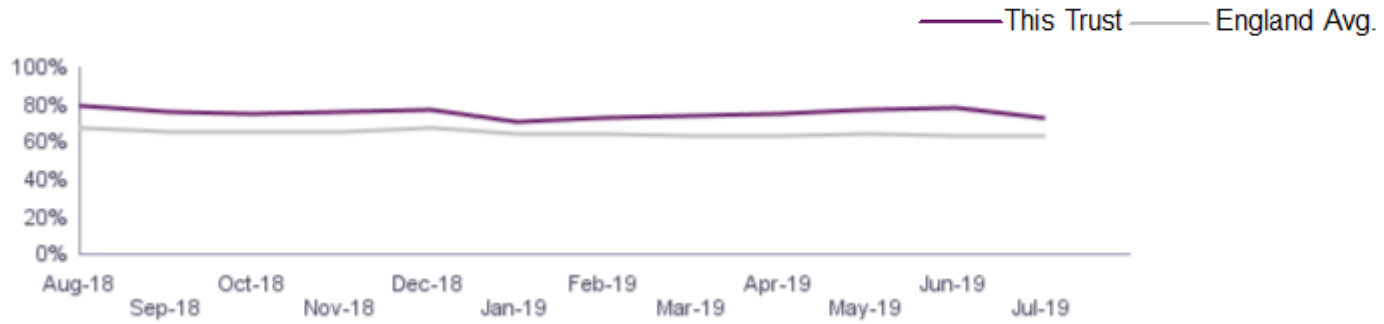
(Source: Hospital Episode Statistics)

Senior leaders attributed positive length of stay results to the introduction of discharge coordinators. They reported that as a result length of stay was showing a downward trend.

Referral to treatment (percentage within 18 weeks) - admitted performance

From August 2018 to July 2019 the trust's referral to treatment time (RTT) for admitted pathways for surgery was consistently higher than the England average.

Trust performance ranged from 70.6% to 79.0% compared to the England average, which ranged from 63.3% to 68.3%.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Four specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Plastic surgery	93.9%	78.9%
Trauma & orthopaedics	84.0%	58.4%
Ear, nose & throat (ENT)	72.1%	60.0%
Oral surgery	59.1%	55.2%

Three specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Urology	64.3%	74.9%
Ophthalmology	49.9%	62.2%
General surgery	49.2%	72.1%

The senior leadership team were cited on the areas where referral to treatment times were not in line with the target and performance needed to be improved, in addition it had been identified there had been a 15% increase in patients being referred to the service in the last 12 months. There was a weekly senior manager's meeting which reviewed referral to treatment times to identify areas of risk which were then escalated to the quality safety, finance and planning meetings. In addition, the team was working hard to make improvements to referral to treatment times which included collaborating with other providers.

We were told that the ophthalmology waiting list had deteriorated due to vacancies in the clinical team and long term sickness. To make improvements the service had been utilising a private provider to assist in seeing the patients on the lists. At the time of our inspection we were told that they were now meeting the 18 week target.

The service was clear that where there were delays in referral to treatment times, patients who were at the greatest risk were prioritised. For example, urology patients on the cancer pathway were prioritised for appointments over minor cases to prevent treatment delays.

The maxillo facial surgery department held an oncology clinic every two weeks where patients could be reviewed by the appropriate specialists which included doctors, dentists and the maxillo facial surgery consultant. Patients who were on the two week pathway and were unable to be seen in the oncology clinic were seen within the two weeks by the consultant in maxillo facial

surgery. There was an emergency clinic available to patients who met the criteria of pain, post-operative complications or failed extractions. Patients were allocated slots based on a needs assessment and nursing staff allocated appointments. We were told that they often overbooked the clinics in order to see as many patients as possible. We were advised these were difficult to manage at times of staffing shortages.

We were told that a number of the maxillo facial surgery lists had long waiting times and some could be up to one year, the main concerns were the joint clinics where patients were seen by the orthodontist and the oral surgeon on the same day. This was mainly due to one of the consultants being based at another hospital in the region. We were told that this was a national issue. The service had identified waiting times as a risk on the risk register.

To make improvements the maxillo facial surgery service had introduced extended nursing roles which enabled them to lead clinics and lists which would be traditionally be led by medical staff, these included local anaesthetics and follow up orthodontic appointments. We were told the extended roles had improved some waiting lists and freed up the medical staff to see new and urgent patients. In addition, the lead for the service had recently attended a 'getting it right first time' meeting which had identified that referral to treatment times for the service needed to be improved and so they were in the development stages of creating an improvement plan.

Langtree ward was focussed on discharging patients early in the day to free up beds. They identified patients who were mobile and self-caring who required little analgesia and allowed these patients to go home and return for their medicines and paperwork once they had been completed. In addition, for patients who were mobile but required regular medicines they utilised the discharge lounge.

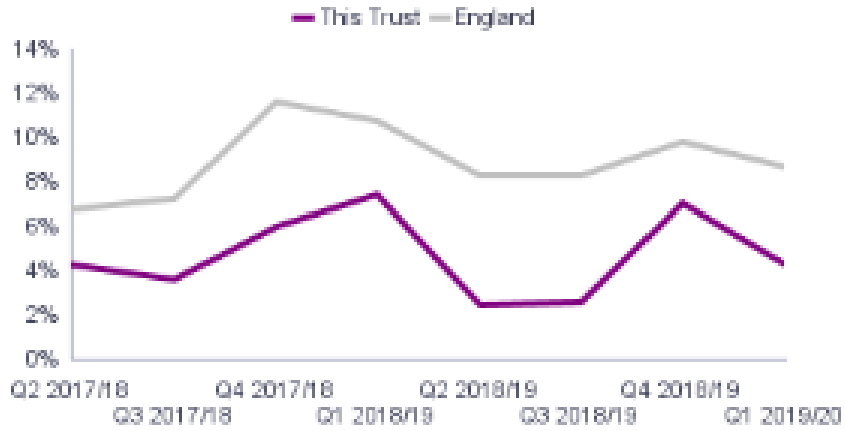
Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

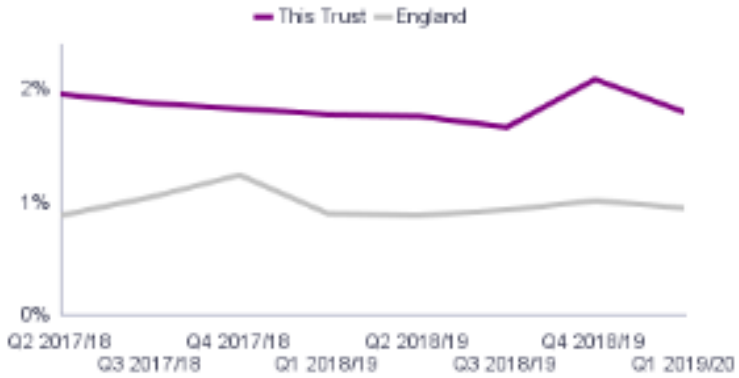
Over the two years, the percentage of patients with cancelled operations and not treated within 28 days has been consistently lower than the England average. Trust performance has ranged between 2% and 7% across the period.

In the latest quarter, Q1 2019/20 the trust cancelled 208 surgeries, and of those cancellations 4% of patients weren't treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Wrightington, Wigan and Leigh NHS Foundation Trust



Cancelled Operations as a percentage of elective admissions - Wrightington, Wigan and Leigh NHS Foundation Trust



Over the two years, the percentage of cancelled operations as a percentage of elective admissions at the trust has been consistently higher than the England average.

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

There was a process in place for recording cancelled operations. Staff completed a cancellation proforma for patients who had their operations cancelled. The staff aimed to re-book an operation date on the day it was cancelled which was within 28 days and aimed to give a date to the patients prior to them being discharged. When they were unable to provide a date, this would be passed to the performance manager who would contact the patient at home and allocate an available date. An incident report form was completed for all cancelled operations which were investigated to identify the root cause.

The table below shows a breakdown of cancelled operations by speciality between October 2018 and September 2019.

Specialty	No
Breast Surgery	8
Colorectal Surgery	24
ENT	12
General Surgery	69
Gynaecology	33
Ophthalmology	3
Oral Surgery	37
Paediatric Dentistry	3
Paediatrics	6
Pain Management	1
Urology	34
Vascular Surgery	2
Grand Total	**232**

(Source: Post inspection data request DR44)

Patient moving wards per admission

From July 2018 to June 2019, the trust reported 6.8% of individuals in the orthopaedic admissions unit at Wrightington Hospital did not move wards during their admission, 73.0% of individuals moved wards once and 20.2% moved more than once.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From July 2018 to June 2019 there were 642 patient moving wards at night within surgery. Langtree Ward saw the highest number of patients moving at night.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Orrell ward had a daily 'HOT' clinic for surgical assessments and ear nose and throat patients. Patients were referred into the clinic via their general practitioner (GP) and were triaged by a team of registered nurses led by an advanced nurse practitioner. Patients were seen either on the day or the following day. Patients who were identified as non-urgent were reviewed and sent home with the necessary intervention and those deemed urgent were admitted. The service prevented unnecessary admissions to hospital and the emergency department. In addition, the advanced nurse practitioner attended the post take ward rounds to identify patients who were fit to go home and await surgery or future appointments to assist with patient flow. The service carried out quarterly audits to measure the number of avoided admissions to the service.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons

learned with all staff. The service included patients in the investigation of their complaint. However, complaint response times did not always meet with the trust's policy.

Patients we spoke with were aware of how to raise concerns if they needed to and felt comfortable to do so. We saw that there were leaflets available about how to raise complaints.

In ward areas we observed that recent complaints were displayed in staff areas and we were told that they were discussed as part of ward meetings. Staff we spoke with were aware of complaints and could describe learning as a result.

We were told that the service had implemented a new initiative when dealing with complaints which included a 'compassionate call'. The process was that the lead investigator would contact the complainant upon receipt of the complaint to discuss the concerns. The leadership team told us this had de-escalated complaints by 20% since its introduction.

Summary of complaints

Trust level

From July 2018 to June 2019 the trust received 118 complaints in relation to surgery (22.6% of total complaints received by the trust).

The trust's complaints and concerns standing operating procedure sets out the different timescales for responding to complaints depending on the complexity of the complaint and issues raised. The agreed response times are 30 days, 40 days, 60 days or 90 days. The trust took an average of 52.1 working days to investigate and close complaints.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	49	41.5%
Patient care	20	16.9%
Communications	13	11.0%
Admissions & discharges (excl delayed discharge due to absence of a care package)	13	11.0%
Appointments	8	6.8%
Waiting times	5	4.2%
Values and behaviours (staff)	3	2.5%
Prescribing	2	1.7%
Pdw	1	0.8%
Trust admin policies procedures incl patient record management	1	0.8%
Facilities	1	0.8%
Access to treatment or drugs	1	0.8%
No subject given	1	0.8%
Total	**118**	**100.0%**

Royal Albert Edward Infirmary

From July 2018 to June 2019 the trust received 73 complaints in relation to surgery at the Royal Albert Edward Infirmary (61.9% of total surgery complaints received by the trust).
The trust took an average of 54.7 working days to investigate and close complaints, this is not in line with their complaints policy of 30 working days to complete complaints.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	32	43.8%
Patient care	16	21.9%
Admissions & discharges (excl delayed discharge due to absence of a care package)	10	13.7%
Appointments	5	6.8%
Communications	3	4.1%
Waiting times	2	2.7%
No subject given	1	1.4%
Trust admin policies procedures incl patient record management	1	1.4%
PDW	1	1.4%
Facilities	1	1.4%
Values and behaviours (staff)	1	1.4%
Total	**73**	**100.0%**

We reviewed a complaint investigation which related to Swinley ward. We saw that from receipt of the complaint to a formal response the service took 23 working days to respond which was in line with their policy. The complaint related to a number of issues which included staff behaviours, patient care, clinical treatment and communication. From our review of the complaint response we saw that there had been a thorough investigation of the concerns raised, the service had identified learning to prevent similar complaints in the future which included additional training for staff and a rotation of working patterns. The service had apologised for the experience the patient had. However, we did see that the complaint response did not advise the patient on the next steps of their complaint if they were not satisfied or direct them to the Parliamentary Health Service Ombudsman for an independent review of their complaint.

Number of compliments made to the trust

From July 2018 to June 2019 there were 416 compliments received for surgery at the trust (13.3% of all received trust wide).

A breakdown of compliments by type and ward area is shown below:

Ward/Area	Beverages	Biscuits	Chocolates	Card/ Letter Thank You	E-mail Thank you	Telephone Thank you	Total
Ward One, Wrightington Hospital		44	40	41		56	**181**
Langtree Ward, RAEI	10	50	50	101	3		**214**
John Charnley Wing, Wrightington Hospital	2	3	6	10			**21**
Total	**12**	**97**	**96**	**152**	**3**	**56**	**416**

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

During our inspection we saw thank you cards displayed in the ward areas we visited.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service, they understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. However, senior leaders in the division were not always visible and approachable in the service for patients and staff.

Staff did not always feel supported by senior leadership in their roles. The theatre department reported that there had been no matron in post for 12 months at the time of our inspection the new matron was due to start in post in November 2019. Senior nurses in the department told us there was limited support from higher management but worked closely to support each other. In addition, theatre nursing and support staff spoke highly of the leadership from the senior nurses in the department but felt that there was limited support from more senior leaders in the division.

Staff were positive about their immediate leadership in the ward managers and senior theatre co-ordinators and lead nurses. However, nursing and support staff on the wards reported that there was little visibility from the senior leadership team in the division and trustwide.

We spoke with divisional leaders of the service who had an understanding of the issues the service faced as a whole. Leaders recognised and were aware of the regional system-wide issues that had an impact on service development. There was uncertainty about where services would be provided from which affected the leaders' ability to make decisions for local progress in the meantime.

The senior leadership team for the specialist services division identified that they did not have concerns about the medical and nursing workforce and felt that recruitment and retention was positive. There were aware of national shortages in certain roles and so were involved in schemes for overseas recruitment. In addition, there was a focus on the development of staff in order to plan for the future. The senior medical team described a proactive approach to developing staff for senior medical roles.

Staff we spoke with from nursing and medical backgrounds felt that their development was encouraged and that there were opportunities to take on additional responsibilities and training.

Vision and strategy

The service had a clear vision for trauma and orthopaedic services at the trust, and there was a trustwide strategy to expand the estate and support turning it into action. Leaders understood the trust's vision and strategy and knew how to apply this in monitoring progress. However, the service did not have a clear vision and strategy for other surgical services which were dependent on progress in regional developments within the wider health economy.

The orthopaedic and trauma service sat within the specialist services division and had a vision for what it wanted to achieve which senior leaders articulated was to become the "leading orthopaedic centre for Greater Manchester". There were trustwide plans to develop the Wrightington site which would enable the expansion of services at that location, however it was not clear what the services would be. The service was part of the Greater Manchester Orthopaedic Alliance so many of the future developments depended on decisions made regionally about how services would be delivered across the patch. The service worked closely with commissioning groups locally and regionally to develop and expand services.

Staff we spoke with were unable to articulate the vision and strategy for the service and the trust.

The service had a workforce transformation plan for nursing and allied healthcare professionals. The plan was in the development stages, but we were told it was looking at how advanced practitioner roles could be developed and used to support the medical team.

Staff we spoke with were aware of the trust values and could articulate these. The values were very much part of the trust's branding and we saw that they were present on posters, stationary, signage and ID badges. Staff's appraisal discussions were focussed on the trust's values and themes. We saw during inspection that staff routinely demonstrated behaviours which were in in line with the trust values.

The majority of the surgical service sat with the surgery division this included ophthalmology, urology, general surgery, maxillo facial surgery and vascular surgery. At the time of our inspection the service did not have a clear strategy with workable plans to turn it into action, this was due to services being re-arranged regionally across Greater Manchester and the uncertainty about what services would be provided at the site. The leadership team was therefore unable to devise plans for expansion and development.

. The main theatres had taken on additional maternity surgery which was staffed by theatre nurses and support staff However, the business case to expand the workforce, stock holding and improve the environment had not been approved at the time of our inspection and had an impact on the surgery team. This had been identified as a corporate risk on the register.

Culture

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

All staff we spoke with were proud to work for the organisation and their department. Staff described the trust as "a great place to work", "the best place I have ever worked" and many said that they "loved their jobs". All staff we spoke with said that they would be happy for their friends and family to treated by the service as they felt they delivered "excellent care".

Staff we spoke with were positive about the team work within their own teams and the wider teams. Staff felt there was a shared goal and they communicated effectively and provided support for each other.

Ward staff reported that the areas they worked in were very busy and at times highly pressured and staff were not always able to take their breaks. We were told that the leadership team on Orrell Ward had recognised this and had introduced a new initiative called a "power pause", this is where staff were actively encouraged to sit down and rest for a few minutes.

The leadership team were aware that there was some uncertainty about the future of services due to regional working. As a result, they were providing regular communication with staff to keep them up to date. The specialist services division had identified the risk of staff feeling isolated as the service spanned across two sites and the provision was much smaller at Royal Albert Edward Infirmary. Senior staff told us they worked across site to support staff and provide visibility. Nurse working groups were being integrated and standardised so that they were the same across both sites and so that the groups met as one team rather than spilt into the two sites.

However, theatre staff had concerns about the addition of maternity services prior to the uplift in staffing.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The surgical core service sat in two divisions: the surgical division and the specialist services division. There was an effective ward to board structure in place to ensure a flow of communication up and down the structures. Ward meetings fed up into the divisional senior nurse meetings, which were escalated up through the divisional quality executive committee, and the trustwide quality and safety committee and then the board. There were weekly trustwide escalation meetings which looked at new risks and incident investigations so that information could be escalated in a timely manner.

Each division created a monthly governance report which were shared with staff. The reports were split into five domains safe, effective, caring, responsive and well led. We saw that they covered incidents, risk, audit results, safety alerts, mortality and morbidity, NICE guidance and complaints. The reports were shared with staff monthly by email. In the theatres department we saw that the reports were printed and available on the corridor for staff to read.

Teams had identified meeting frequencies which varied dependant on the area. The theatre department held monthly team meetings. We were told incidents were discussed as part of these meetings. The meetings were recorded, and the minutes were available for staff who could not attend.

The service had a governance lead for surgery who was available to senior staff. Their time was shared with across the two sites.

There was a weekly senior nurse communication cell which was attended by the senior nursing staff for all wards and theatres. The structure of the meeting was that each speciality provided an update about incidents, complaints and risks, this was also an opportunity for the senior leadership team to share information from higher meetings to take back to the staff on the ground.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They mostly identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision making to help avoid financial pressures compromising the quality of care. However, we identified risks which the leadership team were not sited on.

There was a corporate risk register which each division contributed to, risks which had been scored greater than 15 were inputted onto the corporate risk register. In addition, there was a divisional register for those scoring nine to fourteen and departmental risk registers for all other risks. We saw that the top three departmental risks were displayed in staff areas. During our conversations with senior staff it was clear that they were aware of the risks to their area.

We were given an example of a high priority risk for the specialist services division which was the risk of the ringfenced trauma beds on Aspull ward being filled by non-trauma patients due to bed pressures. We were told that the service had put in place actions to mitigate the risk of the beds not being available for trauma patients this included getting the support of the board to create a standard operating procedure and algorithm. This meant that in order for a non-trauma patient to be admitted to the allocated beds there needed to be executive and consultant approval, in addition for a visible demonstration of the ringfenced beds they had identified the specific male and female beds including the numbers which were protected.

Each division presented their performance to the trust board quarterly to provide a robust monitoring system. They presented information relating to quality, activity and other performance metrics.

Performance, risk and issues featured as part of staff meetings and the weekly communication cell. It was apparent through talking to staff they had an awareness and an understanding of these aspects of the service.

During our inspection we identified concerns with the storage of cleaning fluids which did not meet with the requirements of an estates and facilities alert in 2019. We identified that staff in theatres were not appropriately trained for paediatric life support and that training compliance for medical and nursing staff was low. We raised these concerns with the senior leadership team who were not sited on the issues and had not identified these as a risk. We saw the trust had responded to the estates and facilities alert in relation to the storage of cleaning products, however it was not clear what action had been taken and some areas identified for consideration did not have a response. Following our inspection, we were told that paediatric life support training would be reviewed, and the trust had identified plans to ensure staff receive training in a timely way and hazardous cleaning products were secured.

Information management

The service collected reliable data and analysed it. Managers could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected relevant information to submit to internal and external audits and the systems they used supported this. Senior staff had access to the information they needed to monitor performance and ensure there was sustained or improved standards of care.

The electronic system provided a performance dashboard which was split into five domains safe, effective, caring, responsive and well led. Senior nurses on each ward had access to the performance dashboard for their ward. We saw that the dashboards looked at a range of indicators which included complaints, re-admissions, compliance with national early warning scores (NEWS2) and incidents. Senior nursing staff spoke highly of the dashboard as it enabled them to look at trends through the month to identify potential areas of concern and also benchmark their performance against other wards in the hospital.

Clinical staff had access to patients' records which were primarily electronic. Staff had individual secure access through password protected systems. Staff could access a range of information including investigation results and there were no concerns regarding any delays in receiving these. The electronic system alerted staff to high risk patients who required additional reviews and prompted input from the critical care outreach team.

Important information such as safety alerts, minutes of meetings and key messages were shared in safety huddles, displayed on notice boards in staff areas and communicated to staff via email to help keep them up to date and aware of issues.

Staff had access to important information, such as policies and other guidance, via the trust's intranet.

The service used different IT systems for certain activities and there were no concerns regarding the availability of these systems.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, staff did not always feel engaged by the wider trust and were not aware of the freedom to speak up guardian role.

The trust promoted a 'talk safe' initiative, which was an open forum on the trust intranet for staff to share ideas and experiences of new and different ways of working. The trust had a Freedom to Speak Up Guardian, however, staff we spoke with were not aware of their role. During our inspection the trust was promoting Freedom to Speak Out month.

There was a focus on staff engagement and social events in departments we visited. The trauma and orthopaedic team had regular dog walks, feel good Friday and social events.

On Aspull Ward we observed a dedicated board for staff engagement. We were told that the ward manager wrote a monthly letter to staff thanking them for their hard work and recognising staff achievements in that time.

Staff spoke highly of the engagement from a local level they said they consulted and informed about what was going on in their area of work. Staff felt that communication was effective and that they could contribute ides to improvements in the service and changes to working practices. However, some staff said that there was a lack of engagement from a divisional and trust level.

The service worked closely with commissioners to shape and develop the service. They were involved in a number of external networks for the varying specialities covered within the service. They engaged with external stakeholders regionally to shape and develop services.

The trust's brochure 'Your stay with us' was provided to each patient on their admission. This outlined the trust's services and details of what patients could expect during their admission. The division's monthly quality report identified increased performance in the patient engagement survey results for September 2019, there were eleven out of 12 green scores and one red score. Ten of the questions had increased in their percentage scores compared to August's results.

Specialist nurses in urology services supported a bi-monthly meeting for patients with urological cancer conditions.

Learning, continuous improvement and innovation

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

The governance facilitator for surgery had led on a quality champions initiative which had been put in place. Staff spoke highly of the trust and the service for supporting innovation and service development. We were told how the service was supported to make improvements to breast surgery, which as a result were being performed as day case lists.

The maxillo facial surgery department had local anaesthetic lists clinics which were ran by medical students from a local university. These were ran under the supervision of the consultant. Nursing staff had extended their scope of practice and were supporting medical staff to review orthodontic and local anaesthetic patients.

The trust had its own research department. We were told about a number of clinical research projects which the service currently contributed to which included those for ear nose and throat

conditions, rectal cancer and gall bladder conditions. The service monitored the number of patients who were added to the trial and there were named nursing and clinical leads for each trial.

The orthopaedic clinical leads told us that they had published more than 20 research papers in the last 12 months to share learning nationally. In addition, the team ran medical training courses for external staff to share best practice.

The upper limb service had begun using quality improvement principles to make improvements to the service. This had involved engagement and the involvement of staff who worked in the areas to improve the service.

There were link nurse roles for a number of specialist areas such as deprivation of liberty safeguards, dementia, end of life care, medicines management and alcohol. The link nurses met on a regular basis to share learning and identify areas for improvement in practice. We were given an example of how the deprivation of liberty safeguards link nurses were working on a project to improve the flow charts for capacity assessments. There was a plan to pilot the use of the new assessment tool on the Langtree ward before rolling it out across the trust.

In 2019 the trust invited staff from all areas to participate into a ‘dragons’ den’ style meeting, to submit ideas for delivering improvements in patient care, staff experience and/or financial benefits. Of the 20 shortlisted applications, 10 came from the surgical division, and all were successful in their application for funding.

The urology service had also won the trust’s recognising excellence award for the urological cancer patient support group.

The service held regular mortality and morbidity meetings which had a learning approach and aimed to identify areas for improvement. We were given an example of how practice had been improved as a result of these reviews.

The hip fracture meetings had identified a theme of pneumonia as a cause of death. The service worked closely with the trust’s respiratory medical team who had been involved in a project to reduce aspiration pneumonia and the speech and language therapy team. As a result, swallowing assessments and mouthcare were built into the fractured neck of femur pathway. All patients on the pathway received a swallowing assessment post operatively, patients were prescribed a mouthwash and staff have been educated to ensure that all patients are sat upright when they were in bed during the day. We were told this had improved the number of patients acquiring pneumonia after their operation.

Critical care

Facts and data about this service

Critical care services at Wrightington, Wigan and Leigh NHS Foundation Trust are based at the Royal Albert Edward Infirmary and are co-located to theatres. The service incorporates both the intensive care unit and high dependency unit underpinning specialist and secondary adult services. The service provides a full-time outreach service on a 24/7 basis, staffed by a team of specialist trained nurses and support staff.

The intensive care unit provides a dedicated team of intensivists led by a clinical director who is supported by the multidisciplinary team including pharmacists, dieticians, physiotherapists and microbiologists. Patients transferred from other secondary care services are accepted onto the unit within the critical care network.

The trust has seven intensive care (ICU) and four high dependency (HDU) beds, admitting on average 650-700 patients a year for single and multi-organ failure support. The unit provides highly specialised nursing and medical care to the sickest patients in the hospital.

The nursing staff are supported by a practice educator who works closely with students and new members of staff. Study sessions are provided underpinning the theory and practical education of a variety of elements in critical care. In addition to this staff are further supported onto the critical care course with currently 62.5% of staff having this qualification.

The unit is actively involved in sharing best practice within the Greater Manchester RICON Group.

The trust are also members of the Intensive Care National Audit and Research Centre (ICNARC) case mix programme, allowing the unit to audit patient outcomes.

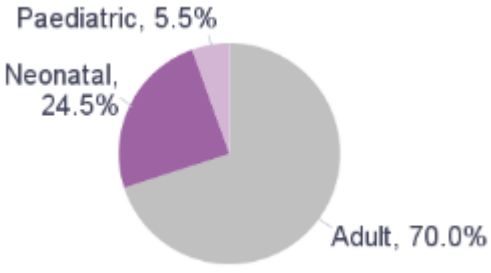
(Source: RPIR – Acute context tab)

The trust has seven intensive care unit beds and four high dependency unit beds, all of which are adult critical care beds.

Breakdown of critical care beds by type, Wrightington, Wigan and Leigh NHS Foundation Trust and England.

This trust

England



(Source: NHS England)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and monitored completion of the training.

Mandatory training completion rates

The trust set a target of 95% for the completion of mandatory training.

Royal Albert Edward Infirmary

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified nursing staff in critical care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-fraud awareness	11	11	100.0%	95%	Yes
Blood collection	7	11	63.6%	95%	No
Blood transfusion	5	11	45.5%	95%	No
Bowel management programme	10	11	90.9%	95%	No
Conflict resolution	11	11	100.0%	95%	Yes
Delirium	9	11	81.8%	95%	No
Dementia awareness	11	11	100.0%	95%	Yes
Emergency planning	11	11	100.0%	95%	Yes
Equality and diversity	11	11	100.0%	95%	Yes
Fire safety	11	11	100.0%	95%	Yes
Health and safety	11	11	100.0%	95%	Yes
Infection prevention		11	0.0%	95%	No
Information governance clinical	11	11	100.0%	95%	Yes
Medical devices	11	11	100.0%	95%	Yes
Medicine safety	11	11	100.0%	95%	Yes
Moving and handling clinical	10	11	90.9%	95%	No
Resuscitation	11	11	100.0%	95%	Yes
Safe use of insulin	9	11	81.8%	95%	No
Slips trips and falls clinical	11	11	100.0%	95%	No

Medical staff training

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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

Staff we spoke with understood their roles and responsibilities to protect vulnerable adults and children. They had received awareness training in female genital mutilation and child sexual exploitation, which was included in their mandatory and statutory training.

Staff had also received training in the government PREVENT strategy to protect vulnerable people from the threat of terrorism and radicalisation to a basic level.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward. During our inspection there was a new born baby on the unit with its mother.

Safeguarding training completion rates

The trust set a target of 95% for the completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in critical care is shown below:

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Prevent	11	11	100.0%	95%	Yes
Safeguarding Vulnerable Adults	11	11	100.0%	95%	Yes
Safeguarding Children Level 2	11	11	100.0%	95%	Yes

At the time of the inspection clinical staff were not yet trained to level three adult safeguarding, as set out in the intercollegiate guidance Adult Safeguarding: Roles and Competencies for Health Care Staff. However, the trust was starting training in December 2019. The guidance expects that all staff will have achieved the appropriate competencies as set out in the guidance by 2021.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Medical staff training

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The unit was clean and had suitable furnishings which were clean and well-maintained.

Clinical areas, offices, corridors and store rooms were visibly clean. Floors, chairs and couches were covered in a wipeable material.

Curtains were disposable and clean and had recently been changed.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning staff were based permanently in the unit.

Staff used records to identify how well the service prevented infections.

At the time of our inspection the unit report that they had no cases of methicillin resistant Staphylococcus aureus (MRSA) infections since September 2014 and no cases of Clostridium difficile (C difficile) since April 2016.

Staff followed infection control principles including the use of personal protective equipment (PPE).

The trust had infection prevention and control policies in place and these were accessible to staff. Staff wore gloves and aprons when caring for patients and disposed of them between patient contacts. Staff on the unit were "arms bare below the elbows" in clinical areas and washed their hands after touching patients.

There was adequate access to handwashing sinks and hand gels. Hand gels were available outside the doors to the unit and staff and visitors were reminded to use them before entering. There was an infection prevention fact sheet available for visitors to the unit.

The critical care unit had three side rooms so that patients with a suspected infection could be isolated.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Hand hygiene audits were carried out monthly. In the three months from May to July 2019, the reported hand hygiene audits in the governance report, showed that 100% of staff observed were following appropriate hand hygiene techniques.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff responded quickly to patient alarms and call bells.

Staff carried out daily safety checks of specialist equipment.

We saw that resuscitation equipment, including defibrillators and difficult airways management trolleys, were available on the units. Records showed that the top shelf of the trolley was checked daily. All resuscitation equipment was checked weekly.

The service kept an inventory of all equipment. They kept a pre-planned maintenance schedule and ensured that equipment was serviced by the due date.

Specialist equipment was serviced by the equipment provider. The service kept a file of all service checks and arranged for servicing by the due date.

There was an electro bio-medical engineering department (EBME) on site, who were responsible for servicing and maintaining other bio-medical equipment in the unit.

The service had enough suitable equipment to safely care for patients. Some larger pieces of equipment were stored in a back corridor but was stored safely and regularly cleaned. Other

clinical stores were well-ordered, neat and stocks were labelled appropriately. All sundry items we checked were within the manufacturers' expiry dates.

Clinical, single-use items were labelled with the cost per unit to remind staff about the cost of wasting stock.

Staff disposed of clinical waste safely.

There were foot operated waste bins in use and clinical waste was stored securely.

The critical care unit appeared to be compliant with the Department of Health published "Health Building Note 04-02" (HBN 04-02) for critical care units. This guidance determines the equipment that needs to be located in a critical care unit and the minimum amount of space required per bed to safely locate and utilise that equipment. The guidance states that each bed space should be a minimum of 25.5m2.

Bed spaces were large though managers on the unit were unsure as to whether they met the 25.5m2. However, there was plenty of room for staff to move around the beds and the spaces were uncluttered.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

The hospital used a national early warning score system (NEWS2). This was a scoring system with the aim of identifying deteriorating patients early and quickly. The early warning scores used an aggregated weighting system with physiological parameters such as blood pressure, heart rate, temperature, respiratory rate, neurological status and oxygen saturation. We saw evidence of the use of national early warning scores in the unit in patient records.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues.

Patient records showed that staff carried out risk assessments on admission and on an ongoing basis to identify patients at risk of specific harm, such as pressure ulcers, risk of falls or nutritional risks. If staff identified patients susceptible to these risks, patients were placed on a relevant care pathway to reduce the risks, such as pressure care using suitable equipment.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health).

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. Nurses took part in safety huddles off the unit two or three times per day and there was a bedside handover for each patient at change of shift.

The service had a major incident plan in place in the event of an unprecedented demand for critical care beds, for example a flu epidemic. The unit was able to take a total of nine intensive care patients with a ventilator. Level two patients could be cared for in the surgery recovery area.

The critical care outreach team provided monitoring and support for patients discharged from the unit to prevent readmissions. They also provided support and teaching to ward staff, to ensure that patients at risk of deterioration and who may require admission to the unit were identified in a timely way.

Nurse staffing

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

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The table below shows a summary of the nursing staffing metrics in critical care at trust level compared to the trust's targets, where applicable:

	Critical care annual staffing metrics						
	July 2018 – June 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		3.5%	9%	4.0%			
All staff	77.2	1.0%	8%	5.4%			
Qualified nurses	61.8	1.0%	7%	4.6%	20 (5%)	150 (38%)	170 (43%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within critical care were analysed for the past 12 months and no indications of increase, deterioration or change were identified in monthly rates for vacancy, turnover, bank and agency use.

The ward manager could adjust staffing levels daily according to the needs of patients.

The number of nurses and healthcare assistants matched the planned numbers.

Managers told us that nurses were staffed to establishment though there had been some long-term sickness over the summer months.

Nurses had been moved off the unit on a regular basis to work on other wards or departments that were short-staffed. The unit had developed a risk assessment tool to measure the capacity of the unit to release staff. This scored the number of empty beds, number of staff, numbers of level two and three patients and other situational factors, such as number of patients with delirium, deteriorating patients, patients requiring one-to-one care who cannot be left unattended,

number of patients being prepared for transfer and where there were more than four staff on shift with less than one year critical care experience.

Based on the scoring outcome, the capacity of the unit to release staff was assessed and safe staffing levels could be maintained. Any staffing moves were recorded on the daily risk assessment and on the electronic staffing tool.

Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards state that there must be a supernumerary clinical co-ordinator or shift leader (sister or charge nurse, band 6 or 7) on duty 24 hours a day, seven days a week on critical care units.

The responsibility of the supernumerary shift leader was to provide nursing leadership and support to optimise safe standards of patient care on each shift; coordinate and supervise nurse staffing; facilitate admissions and discharges to ensure effective patient flow; liaison with the multidisciplinary team and other departments to ensure efficient, effective and safe care is delivered in a timely manner.

The unit had a supernumerary shift leader on each shift but if the unit became full they had to care for a patient. This was on the unit risk register and the risk score had recently been increased because of increasing instances when this had happened. In March 2019 there were five shifts with no supernumerary shift leader and four of those shifts had a minimum of two inexperienced nurses on duty; in April 2019 there were seven shifts with no supernumerary shift leader and five of those shifts had between one and three inexperienced nurses on duty; in May 2019 there were 44 shifts with no supernumerary shift leader and between one and four inexperienced nurses on duty; from June to August 2019 there were 24 shifts with no supernumerary shift leader. The service was monitoring compliance for discussion and review at the monthly risk review meeting.

In the event of unforeseen short staffing, the quality lead, matron or practice educator were able to step in and act in a clinical capacity as part of the nursing numbers.

The unit had a critical care outreach team which provided monitoring and support for deteriorating patients and patients discharged from critical care to prevent admissions and readmissions. This team provided cover 24 hours a day, seven days a week and also saw patients in Wrightington Hospital. Two band six nurses had just been recruited to the team and were due to start work with the trust in the coming weeks. This brought the numbers on the team to around nine whole time equivalent nurses.

Vacancy rates

The service had low and/or reducing vacancy rates.

From July 2018 to June 2019, the trust reported a vacancy rate of 1.0% for qualified nursing staff in critical care.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

At the time of our inspection, the unit had a vacancy of 0.74 whole time equivalent band five nurse. However, the band seven nurse had been seconded to the matron role and the band six nurse had been seconded into the band seven role. These uplifts meant that the money available to fill this vacancy was being used elsewhere.

Turnover rates

The service had low and/or reducing turnover rates.

From July 2018 to June 2019, the trust reported a turnover rate of 7% for qualified nursing staff in

critical care. This was lower than the trust target of 9%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Bank and agency

The unit did not generally use bank staff and had only used an agency nurse once in the last year. Staff shortages could be covered by nurses carrying out overtime.

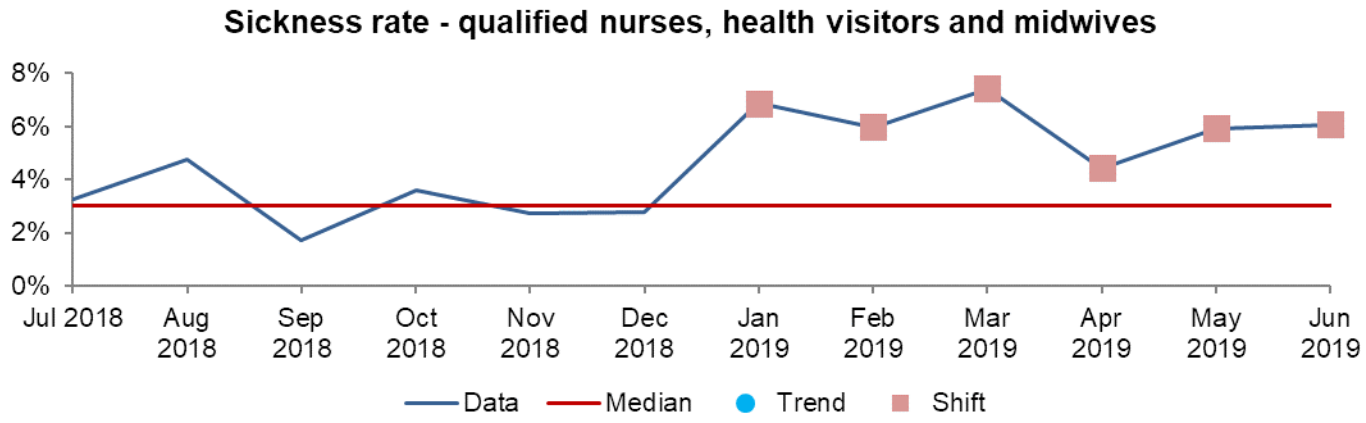
Sickness rates

The service had an annual sickness rate that was higher than the trust target of 4%.

From July 2018 to June 2019, the trust reported a sickness rate of 4.6% for qualified nursing staff in critical care.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Managers told us that there had been some long-term sickness over the summer months, but the sickness was not work-related.



Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from January 2019 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Medical staffing

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

The table below shows a summary of the medical staffing metrics in critical care at the Royal Albert Edward Infirmary from July 2018 to June 2019 compared to the trust's targets, where applicable:

	Critical care annual staffing metrics						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target	N/A	3.5%	9%	4.0%			
Medical staff	8.0	2.0	0.0%	0.87%	0	0	0

(Source: Provider Further Information Request DR61)

The provider told us that they had an average of eight whole time equivalent medical staff on the unit from July 2018 to June 2019.

Vacancy rates

The service had low and/or reducing vacancy rates.

The service had two medical staffing vacancies at the time of our inspection. Both posts had been recruited to which meant that full establishment would be achieved by March 2020.

(Source: Provider Further Information Request DR61)

Turnover rates

The service had low and/or reducing turnover rates.

From July 2018 to June 2019, the trust reported an annual turnover rate of 0.0% for medical staff in critical care.

(Source: Provider Further Information Request DR61)

Sickness rates

The service had low and/or reducing sickness rates.

From July 2018 to June 2019, the trust reported an annual sickness rate of 0.87% for medical staff in critical care. This rate was for the whole anaesthetic medical group that was 36 staff in total.

(Source: Provider Further Information Request DR61)

Locum staff usage

The trust did not use bank or agency locums in critical care.

(Source: Provider Further Information Request DR61)

The service was meeting the medical staffing standards set out in the Guidelines for the Provision of Intensive Care Services. This includes the unit being led by a consultant in intensive medical care, daytime consultant to patient ratios not exceeding a range between 1:8 and 1:12 and a

consultant in intensive care medicine being immediately available 24 hours a day, seven days a week.

Allied health professional staffing

Physiotherapists

The Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards state that there should be input from physiotherapy on the daily ward round and there must be a physiotherapist of adequate experience and seniority who can construct a suitable weaning plan for complex patients. Physiotherapy staffing must be adequate to provide the respiratory management and rehabilitation components of care. The suggested staffing levels are that there should be one physiotherapist to every four beds.

There were five physiotherapists who worked with the critical care unit. These were, one band seven (15 hours per week); one band seven (35 hours per week); one band six (37.5 hours per week); one band six (30 hours per week) and one band five (37.5 hours per week).

Cover was provided on the unit seven days a week from 8am to 4pm with physiotherapists on call overnight from 5pm to 8am.

Occupational Therapists

The Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards state that the rehabilitation needs of patients should be assessed within 24 hours of admission into critical care and eligible patients must receive a rehabilitation prescription on discharge from critical care. Patients receiving rehabilitation should be offered a minimum of 45 minutes of each active therapy that is required for a minimum of five days a week. The suggested staffing levels are that there should be 0.22 whole time equivalent occupational therapists per bed in a critical care unit.

The service had access to an occupational therapist, but they were not readily used on the unit and were not providing the minimum suggested amount of active therapy to those patients identified as requiring occupational therapy.

Dietitians

The Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards state that all patients unable to take oral intake must normally have nutrition support commenced on admission. There must be a dietitian as part of the critical care multidisciplinary team and the lead dietitian will be involved in the assessment, implementation and management of appropriate nutrition support. The suggested staffing levels are that there should be 0.05-0.1 dietitians per bed in a critical care unit and that the lead dietitian should be a minimum of a band 7.

The service had access to one whole time equivalent dietitian who visited the unit five days a week from Monday to Friday. There was no weekend service. They attended the ward round when possible but were not attached full time to the unit.

Speech and Language Therapists

The Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards state that all patients with a tracheostomy must have communication and swallowing needs assessed when the decision to wean from the ventilator has been made and the sedation hold has

started. There is no national guidance on the minimum number of speech and language therapists that should be attached to a critical care unit.

The service had access to a speech and language therapist who visited the unit five days a week from Monday to Friday. There was no weekend service.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Medical records were electronic and comprised a range of clinical records, assessments and care plans.

We examined five sets of patient records. All showed that there was a summary of events requiring admission to critical care recorded, as well as a consultant review on admission. The records showed that there was evidence of a venous thromboembolism (blood clots in a vein) assessment; evidence of daily ward rounds; assessment of fluid state; review of in-dwelling lines; review of sedation and antibiotics (if applicable); evidence of input from the multidisciplinary team; assessment of pressure areas and nutritional status. All records showed that the patient was admitted to critical care within four hours of the decision to admit.

Patient notes were comprehensive, and all staff could access them easily.

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

Records were stored securely.

Medicines

Staff followed systems and processes when safely prescribing, administering, and recording medicines.

The trust used electronic prescribing which included details of the patient's allergy status.

A dedicated critical care pharmacist provided a clinical service to the unit. They were supported by pharmacy technicians. This included checks on patient's medicines when transferred to the unit (medicine reconciliation). Medicines were stored securely in locked areas, including fridges and storage cupboards for IV fluids.

Controlled drug registers were accurately completed and daily checks on medicine stock balances signed by two staff members.

The pharmacist carried out monthly medicine safe storage audits on the unit.

Daily temperature monitoring checks were completed on the clinic room fridge.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.

The critical care pharmacist clinically checked the electronic prescribing records for all patients on the unit on admission and on prescription of new medicine. They also completed clinical checks on medicines prescribed to prevent venous thromboembolism for appropriate dose. They attended ward round.

Staff followed current national practice to check patients had the correct medicines.

Medicine reconciliation was completed by the critical care pharmacist using the patient's summary care records. Patient's consent was obtained, however due to the nature of the unit this was not

always immediately possible. Patient confirmation of the medicine reconciliation was included as part of the process. Electronic summaries were completed ready for patient discharge.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

There were clear instructions regarding the administration of when required medicines, and medicines controlling behaviour stopped when no longer required.

We examined seven patient prescription records and found that all prescriptions were signed and dated; allergies had been documented; any medicines not administered had a reason documented; antibiotics had been prescribed according to national guidelines and venous thromboembolism prophylaxis measures had been taken to diminish the risk of deep vein thrombosis and pulmonary embolism.

Incidents

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

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

The service looked for trends and themes in incidents reported and a breakdown of all incidents reported were published in a quarterly governance report for the unit. The highest number of incidents reported related to discharge related incidents (mainly delayed discharges from the unit). In the six months from March to August 2019, there were 56 discharge related incidents. This compared to the second highest number of incidents reported in this period of 14 patient safety incidents.

A mortality and morbidity meeting took place every four to six weeks and involved consultants, junior and student doctors, nurses, the assistant director of nursing, ICNARC clerks and a microbiologist. We were told that the meeting followed a standard proforma to examine every death that had happened on the unit.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust reported no incidents which were classified as never events for critical care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from August 2018 to July 2019.
(Source: Strategic Executive Information System (STEIS))

During the period March 2019 to August 2019 there were 96 incidents causing no harm to patients; 13 causing minor injury and three that had a short-term effect on the patient.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, no falls with harm and no new catheter urinary tract infections from August 2018 to August 2019.

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

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

The critical care unit at Royal Albert Edward Infirmary supplied patient data throughout the year to the intensive care national audit and research centre (ICNARC). This meant that care delivered, and mortality outcomes were benchmarked against similar units nationally. The critical care unit employed ICNARC clerks to maintain, collate and submit the data.

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

The Chelsea Critical Care Physical Assessment Tool (CPAX) is a tool that was developed to predict the place of discharge and rehabilitation needs of patients in critical care units. The tool scores aspects of physicality, such as respiratory function, movement, sitting, standing, balance, and grip strength and allocates score of zero to five. The overall score gives a prediction of where the patient may need to be discharged to; for example, home or a rehabilitation unit, and what their rehabilitation needs may be, for example, community support or daily nursing, required in the short or long-term. The service used this tool to start patient physicality assessments as soon as possible and follow through when the patients were moved onto other hospital wards. This was in line with National Institute for Health and Care Excellence guidelines CG83, regarding rehabilitation after critical illness in adults.

There was a range of local policies and procedures and standard operating protocols in place, which referenced evidence-based guidance, and these were easily available to staff on the trust intranet. There were policies in place for admission and discharge; transfer; referral to and from critical care; organ donation; life limiting treatment and withdrawal; infection prevention and control; weaning of long-term ventilated patients and patient and carer information.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had support with nutrition and hydration to meet their needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. There was fluid balance monitoring for patients in place, which included hourly and daily totals of input and output. We saw that they had been completed appropriately.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Nutritional risk scores were seen to have been updated and recorded appropriately on patient notes.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it, this included dietitians and speech and language therapists working in the service who supported patients for five days a week.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Individual care plans included pain management assessments for all patients. This included observing the signs and symptoms of pain.

Patients received pain relief soon after it was identified they needed it or they requested it. Pain relief was routinely prescribed as part of sedation management.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers and staff used the results to improve patients' outcomes.

ICNARC Participation

The trust has one unit (Royal Albert Edward Infirmary Intensive Care Unit) which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered, and patient mortality could be benchmarked against similar units nationwide.

(Source: Intensive Care National Audit Research Centre (ICNARC))

ICNARC Results

Royal Albert Edward Infirmary

The table below summarises performance at the for the Intensive Care Unit at Royal Albert Edward Infirmary in the 2018 ICNARC Audit.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other Trusts**	**Met national standard?**
Crude non-clinical transfers *(Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)*	0.0%	Within expected range	Met
Crude, non-delayed, out-of-hours discharge to the ward proportion *(Discharge out-of-hours is associated*	2.8%	Within expected range	Did not meet

with increased risk of mortality)			
Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours) *(Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day*)	3.5%	Not in the worst 5% of units	Did not meet
Risk-adjusted hospital mortality ratio (all patients) *(Risk-adjusted measures take into account the differences in the case-mix of patients treated*)	1.0	Within expected range	No current standard
Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% ('lower risk' patients) *(Risk-adjusted measures take into account the differences in the case-mix of patients treated*)	0.8	Within expected limits	No current standard

Audit results guide

(Source: Intensive Care National Audit Research Centre (ICNARC))

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers used information from the audits to improve care and treatment.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Managers shared and made sure staff understood information from the audits.

Nursing staff on the unit undertook a number of monthly audits.

Negative or failing results and themes from the audits were flagged to a manager for follow-up, learning and improvements to be sought.

Improvement was checked and monitored.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. The service had an intensive care training record for each staff member.

New nursing staff on the unit worked eight weeks supernumerary. Following the supernumerary period, nurses would start level one of the advance nurse practitioner course that they should complete within 12 months. After this, they would commence level two that should be completed

within 18 months and then they could apply for level three that led them to the critical care nursing award. This was run in conjunction with a local university.

Agency and bank staff received a local departmental induction on arrival to their shifts.

Band five physiotherapists underwent a training programme so that they could act as on-call physiotherapists on critical care.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

From April 2018 to March 2019, 88.8% of staff within critical care department at the trust received an appraisal compared to a trust target of 90%.

Only one staff group met the 90% target.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received appraisal	Eligible staff	Completion rate	Trust Target	Met (Yes/No)
Nursing and midwifery registered	57	63	90.5%	90%	Yes
Additional clinical services	10	12	83.3%	90%	No
Administrative and clerical	4	5	80.0%	90%	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Qualified nursing staff

As of July 2019, the trust reported that 35 nursing staff had a post registration award in critical care nursing.

In the Royal Albert Edward Infirmary critical care unit 63% of nursing staff had a post registration award in critical care nursing. This was above the Intensive Care Society core standard for at least 50% of staff to have completed this training.

Site/Location/Unit	Total number of nursing staff in unit (qualified)	Total number of nursing staff with post registration award
Royal Albert Edward Infirmary-ICU HDU	56	35

The trust noted that of the remaining staff who do not have the qualification, six are currently studying, nine are awaiting a date to start and six will not undergo the course.

We saw evidence that staff were trained in a range of specialised equipment on the unit.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

The practice-based educators supported the learning and development needs of staff.

The service had a whole-time equivalent practice-based educator who was funded by the critical care network.

The practice-based educator on the unit was responsible for completing the first personal development review for new staff and supported new staff through the first twelve months of their employment and completion of the step one critical care competencies. They also carried out work with the Critical Care skills Institute being funded by the critical care network. The practice-based educator also arranged mandatory training courses for staff and ran acute illness management (AIM) courses on behalf of the Critical Care Skills Institute. These courses were also available to healthcare assistants.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

There were a number of link nurses in place who developed specialisms in clinical areas and trained other nurses in their specialisms. There were link nurses for methicillin resistant Staphylococcus aureus (MRSA); harm free care/safety thermometer; resuscitation trolleys; hand hygiene; moving and handling; cuff pressures; delirium; nursing documentation; IV fluids and nutrition; safety huddles; vascular access devices and audits.

Managers identified poor staff performance promptly and supported staff to improve.

Nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.

Trainee medical staff had an appraisal and revalidation process in place and opportunities to undertake training.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

There was also a monthly multidisciplinary meeting involving nurses, doctors and allied health professionals, along with theatre colleagues, to discuss patients on the unit and their care and treatment and governance. The meeting was led by the quality lead who managed the agenda and action plans arising.

There was a clinical handover multidisciplinary meeting at the beginning of each shift that involved the doctor handing over, the nurse-in-charge and the outreach practitioner for the day.

There were two daily nurse-led ward rounds that took place every day. Pharmacists and physiotherapists did not usually attend the ward round but raised any concerns with the consultant beforehand and were available for input if required.

Nurses took part in safety huddles which took place at the start of each nursing shift, during which specific patient needs were discussed and any incidents that had taken place.

Staff worked across healthcare disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The outreach team had a questionnaire to assess patients' mental wellbeing and refer for additional psychological support where appropriate.

Seven-day services

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

Staff on wards could call for support from the critical care outreach team and physiotherapists seven days a week.

Consultants led daily ward rounds on all wards, including weekends.

The occupational therapist, dietitians and speech and language therapist did not work on the unit at weekends.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

There were a range of leaflets available on the unit for patients and relatives, for example about oral health.

Two nurses had undertaken a course on smoking cessation so were able to support patients with this and give advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

There were assessments of mental capacity or delirium recorded in the patients' records. The service used the Richmond Agitation and Sedation Scale (RASS), which measured the agitation or sedation level of a patient.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

We did not see any deprivation of liberty safeguard applications for patients on the unit. In most instances, the deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1) (the right to liberty) of the Human Rights Act 1998 and there was therefore no requirement for a deprivation of liberty safeguard application if a patient was receiving life-saving treatment on a critical care unit.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Trust level

The trust set a target of 95% for the completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training courses from April 2018 to March 2019 at trust level for qualified nursing staff in critical care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	11	11	100.0%	95%	Yes

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

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

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The service had a bereavement box on the unit. This was based on the swan symbol end of life care model which is recognised as good practice end of life care. The box was used when a patient on the unit was dying or had died. It contained comfort blankets, swan bags for the patient's possessions; comfort bags for relatives prepared by local Brownie and Guide packs and bags for patients rings or locks of hair.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

All patients on the unit had a patient diary and there was a well-embedded system of staff completing the diaries. Relatives were also able to write in the diaries. Messages in the diaries from staff were addressed to the patient and told them in non-medical terms what sort of a day

they had and whether they had undergone any procedures. They allowed the patient to get to know the nurses who had cared for them during their stay, even if they had been sedated for long periods.

One of the nurses on the unit ran a monthly patient diary clinic with a nurse from the outreach team where patients were invited to go through the diary and ask any questions. Patients were also asked whether they wanted to visit the unit and given as much time as they needed to read through the diary.

There was a process in place for destruction of those diaries that were not wanted by patients. Diaries of those patients who had died were offered to their relatives.

The same staff nurse who ran the diary clinics also ran a six-weekly afternoon tea for ex-patients in collaboration with a local supermarket. The meeting was led by ex-patients and allowed recently discharged patients to speak to people who had been through the same experience. Staff on the unit attended the meeting in their own time to give support and answer questions.

Staff supported patients to make advanced and informed decisions about their care.

The feedback from the Friends and Family Test was positive.

Patients and relatives we spoke with told us that they had been fully informed of the care given all the way through their stay. They said that the nurses knew as much about the patient and their care and treatment as the consultants and could answer any questions without having to ask a doctor. A patient told us that the care had been excellent, and the care could not be faulted.

Is the service responsive?

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population.

Critical care units across Greater Manchester worked together to understand and deliver appropriate services to the local population and the whole of Greater Manchester.

Facilities and premises were appropriate for the services being delivered.

The service had suitable facilities to meet the needs of patients' families.

There was a comfortable waiting area and we saw that sandwiches, snacks and drinks were placed in there during afternoon visiting times. The service had a fold-down bed that could be used if relatives needed to sleep in the unit overnight. The service had systems to help care for patients in need of additional support or specialist intervention.

The Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards state that patients discharged from intensive care should have access to an intensive care follow-up clinic. This is because critically ill patients have been shown to have complex physical and psychological problems that can last for a long a time.

Patients were invited to follow-up diary clinics following their discharge from hospital. This enabled them to go through the diary and learn what had happened to them during their stay on the unit and ask any questions. During the clinic, the nurse took details of how the patient felt and any delirium disturbances they had experienced. They made appropriate signposts to further support. Details of the conversations were fully documented.

The critical care outreach team followed up all patients who had been discharged and carried out psychological assessments and could refer patients for appropriate therapy. In addition, patients were invited to follow-up coffee morning events, hosted by a local supermarket where they could speak to other patients and clinical staff to receive support and share their experiences. Details of who had attended the support group, patient experiences shared and themes arising were fully documented for further follow up by appropriate clinicians.

Meeting people's individual needs

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

There were adequate facilities in the critical care unit to allow access and use by disabled patients and visitors, including wide corridors.

Staff made sure patients with mental health needs, learning disabilities or living with dementia, received the necessary care to meet all their needs.

The service was able to refer patients for psychological support. The critical care outreach team assessed the psychological needs of patients when providing follow-up support to patients.

Staff supported patients living with dementia and learning disabilities by using patient passports.

There was a critical care passport for patients in place that allowed patients and relatives to state any characteristics that may be protected under the Equality Act, such as any physical or learning disabilities and religion or spirituality and this informed staff of any adjustments that may need to be put in place for the patient.

Staff received training in dementia and how to care for patients who were living with dementia. There was a dementia link nurse in place. There was also a link nurse who specialised in patient delirium.

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

The service had information leaflets available. Information leaflets about services, discharge and bereavement advice were available. Leaflets could be provided in different languages or other formats if requested.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us that they had access to a face to face interpreting service when required and this would be booked in advance whenever possible.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

We saw evidence of strong working with the maternity service to support women using critical care services to be with their baby and promote skin-to-skin care.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted and treated and discharged patients in line with national standards

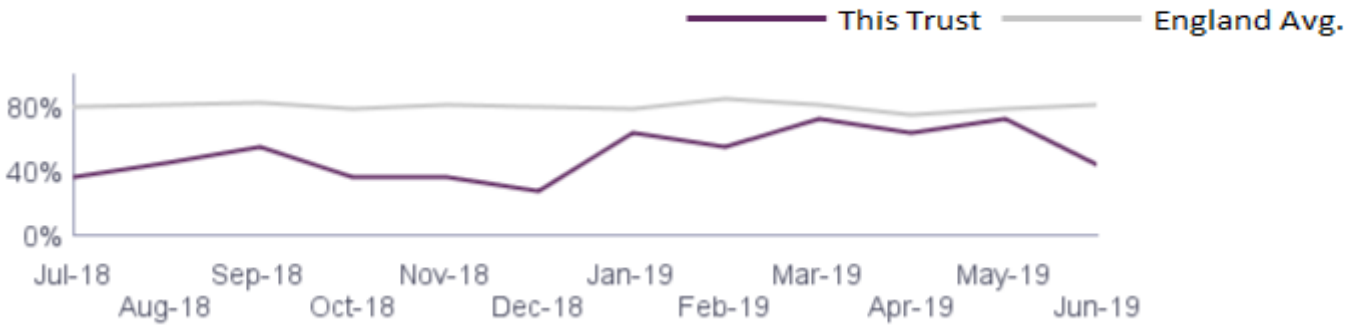
Bed occupancy

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

We examined five sets of patient records and saw that all the patients were admitted to the unit with four hours of the decision being made to admit them.

From July 2018 to June 2019, Wrightington, Wigan and Leigh NHS Foundation Trust has seen adult bed occupancy levels consistently below the England average levels. Occupancy levels were generally higher from January 2019 onwards.

Adult critical care Bed occupancy rates, Wrightington, Wigan and Leigh NHS Foundation Trust.



Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Managers and staff worked to make sure patients did not stay longer than they needed to.

In the Intensive Care National Audit and Research Centre report for April 2018- March 2019 the unit reported that 5% of available bed days in the unit were after 8 hours from the time at which the person was ready to be discharged. This was slightly better than the average of 5.2% for similar units. In the same report the unit reported that 2.8% of available bed days in the unit were after 24 hours from the time at which the person was ready to be discharged. This was better than the average of 3.1% for similar units.

Managers monitored the number of delayed discharges. While the data for discharge was slightly better than other units it had deteriorated over the last few years and managers told us that delayed discharges from the unit to a ward remained an issue and this was due to a lack of available beds to which to transfer a patient.

Delayed discharges were high on the unit risk register and was raised regularly at departmental meetings though no solution had been reached as the number of appropriate available beds in the hospital remained critically low.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Mixed sex breaches remained an issue because delayed discharges from the unit remained high. Patients sharing an area with members of the opposite sex became a mixed sex unjustified breach if a patient was ready to be discharged to another ward and this had not happened within four hours. Staff were appropriately reporting these breaches nationally.

In the Intensive Care National Audit and Research Centre report for April 2018- March 2019 the unit reported that 3% of discharges were out of hours (between 10pm and 6.59am) which was worse than the average for similar units which was 1.6%.

A representative from the unit generally attended hospital bed meetings that took place daily and reported back the situation on available beds if a patient was being prepared for discharge.

Managers monitored that patient moves between wards/services were kept to a minimum.

Managers and staff worked to make sure that they started discharge planning as early as possible.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Summary of complaints

Trust level

From July 2018 to June 2019 the trust received two complaints in relation to critical care at the trust (0.4% of total complaints received by the trust).

The trust's complaints and concerns standing operating procedure sets out the different timescales for responding to complaints depending on the complexity of the complaint and issues raised. The agreed response times are 30 days, 40 days, 60 days or 90 days. The trust took an average of 48.0 working days to investigate and close complaints.

Both complaints for critical care relate to clinical treatment.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

We reviewed both complaints received and saw that full explanations had been given to the families who had complained following a full investigation. Appropriate apologies had been given and duty of candour had been followed.

Number of compliments made to the trust

From July 2018 to June 2019 there were 255 compliments about critical care at the trust. (8.2% of all received trust wide).

A breakdown of compliments by type is shown below:

Ward/Area	Beverages	Biscuits	Chocolates	Misc.	Card/ Letter Thank You	Total
ICU/HDU	22	45	73	20	95	**255**

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

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

The critical care unit was part of the surgical division, led by a divisional medical director and an interim deputy director of operations and performance

At a local level, the nursing and care staff in critical care were led by an interim matron who was supported by sisters and charge nurses. The consultants were led by a lead consultant.

They were supported from above by a divisional directorate manager and divisional director of nursing and a divisional performance manager.

Staff told us that the leadership was excellent, and they felt well supported in their roles. Staff told us that senior leaders were visible on the unit, but trust executives were not seen very often.

We observed that the matron was “hands on” on the unit and worked well with the clinical lead to manage priorities and issues facing the service and supported staff to take on additional roles.

Allied professionals told us they had well set out goals and performance development reviews. They told us that the doctors and consultants cascaded training to other staff on a regular basis.

Vision and strategy

The service had a vision and plans for the future but did not have a formal strategy or delivery plans for how to turn it into action.

An up to date trust strategy was in development at the time of our inspection and a review of all hospital services was taking place so that service priorities could be fed into the overall strategy and developed in more detail at a local level.

Senior managers for the critical care unit were focused on what their strategic goals would be. One of the strategies was to strengthen the outreach team so that more admissions could be avoided, and work could be done in the community to support long-term tracheostomy patients. The unit was also planning to develop its relationship with the alcohol specialist team and maintain and strengthen their relationship with the rapid access, interface and discharge (RAID) mental health team.

Culture

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

Staff felt supported to try new things and suggestions for improvements were listened to.

Staff were encouraged to take up career development opportunities.

We saw that interactions between doctors and nurses and allied health professionals were open and honest and that staff of all grades worked well together as a cohesive team.

Staff told us that staff of all grades and disciplines worked well together in a very friendly atmosphere and lower grade staff were not afraid to challenge the safety culture if they felt this was necessary.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a monthly intensive care multidisciplinary meeting which was consultant led and attended by senior critical care staff, such as the matron, senior nurses, consultants and the directorate manager, supported by the ICNARC clerk, quality lead and practice educator.

There was a clear fixed agenda for the meetings that covered Greater Manchester Critical Care Network updates; feedback from mortality and morbidity meetings and coroners' communications; risk management and patient safety; quality and safety; infection prevention control and performance. There was an ongoing action plan arising from the meetings.

Key outcomes were escalated for review by the surgery division quality executive committee. This committee reported high level risks to the risk and environment management committee, that reviewed risk registers and corporate risks, or quality issues to the quality champions. They in turn fed relevant information to the quality and safety committee who escalated reports to the trust board.

There was a clear governance escalation and framework in place to enable information to pass from the unit to the trust board and from the board to the critical care service.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was a critical care risk register in place. The register had review and completion dates. We saw that all risks had been appropriately reviewed monthly and assurances or gaps in assurances or controls had been completed. There was also an action plan for each risk.

At the time of our inspection there were 21 risks on the service risk register. Fourteen of these risks had been mitigated sufficiently to meet their target risk score and one risk had a current score that was lower than the target risk (patient injury due to confusion or delirium). Of the other six risks, four were classed as moderate or low risks. These included delayed discharges; sharing video laryngoscopes with surgery; use of non-safe sharps and driving for work.

Two risks had a current score of 15 and were classed as high risk. These were on the corporate risk register and were the failure of the clinical information system and not having a supernumerary shift leader on every shift.

The Greater Manchester Critical Care Network had a Risk Over Network (RICON) project and staff from the service were involved in each risk group. The aim of this project was to improve patient safety by allowing different units to share problems and best practice to improve the quality of care offered to all critical care patients in the network and allow collaborative working. It focused on six main areas of risk: infection and ventilator associated pneumonia; communication failures; lack of access to critical care; harm from mechanical ventilation; medication safety and airway safety.

The critical care unit was part of the Greater Manchester Critical Care Network (GMCCN) that conducted an annual peer review of the unit. The latest report was published in June 2019. It highlighted some areas of good practice and improvements, such as high quality data submitted to the Intensive Care National Audit and Research Centre (ICNARC); the unit having a dedicated governance lead; the patient acuity and staffing risk assessment tool; delivering safer airway management in intensive care (SAMI) training; an electronic screen in the staff room to deliver messages to staff; and a very engaged nursing workforce who were keen to develop and improve the service.

The report also highlighted some areas where the service could make improvements although there were no immediate risks or serious concerns identified. Areas for improvement included, patient flow and reducing the number of delayed discharges; improving compliancy with having a supernumerary shift leader on each shift; monitoring 12 hour review of patients; more engagement with RICON (risk over network) groups run by the Greater Manchester Critical Care Network; a more structured mortality review; introducing PA allocation for the critical care lead clinician and reviewing readmissions using a structured proforma to determine whether they were avoidable or not, although it was acknowledged that very few patients were readmitted within 48 hours of discharge.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The units were required to submit data on a regular basis to the Intensive Care National Audit and Research Centre (ICNARC). This ensured that the quality of the units and comparison with similar units could be monitored and analysed. The data was available in the public domain.

In order to ensure that performance data was accurate, valid, reliable, timely and relevant and that the data was submitted as required, there were ICNARC (or audit) clerks employed by the unit. Their responsibility was to collect and collate patient and treatment data and submit it to ICNARC in the correct format. They also audited and analysed data for use in other internal reviews, such as the review on mortality conducted by the consultant leads.

There was a secure electronic medicines prescription system in use on the unit.

There was a secure electronic incident reporting system in place that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken.

Staff had access to policies and procedures via the trust secure intranet.

Patient records were electronic and were stored securely.

Engagement

Leaders and staff actively and openly engaged with patients, staff, and the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw that staff at all levels in the service were involved in driving improvements, meeting strategy goals and delivering good outcomes.

Staff were actively involved in the Greater Manchester Critical Care Network Risk Over Network (RICON) groups. Staff including charge nurses, doctors, sisters, the pharmacist and clinical lead were part of collaborative working groups for each risk area identified.

The clinical lead encouraged nurses to get involved in research projects either on the unit or across the Greater Manchester Critical Care Network.

There were a range of communications to staff to advise them of ongoing changes and improvements, such as newsletters, and staff awards were in place to celebrate successes.

Former patients were engaged in leading the critical care coffee morning support group held in a local supermarket.

We saw that the service sought the views of patients and families to improve the service. There were satisfaction with care surveys in the relatives waiting area for relatives to complete. These asked about how the patient was treated, how they were treated as visitors, observations about teamwork of staff, communication from nurses and doctors and the care given by them, facilities and the atmosphere on the unit.

Outcomes from the surveys were published in the quarterly governance reports and used to drive improvements. From March to August 2019, all responses to the survey had been positive.

Learning, continuous improvement and innovation

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

The service had a quality lead who was enthusiastic and actively committed to continually improving the service.

Staff on the unit were given the opportunity to carry out projects and activities to improve patient outcomes, for example, the nurse who developed and ran the patient diaries and follow-up clinics. Staff were committed to attending the follow-up coffee mornings in their own time to offer support.

The patient diaries were personal to each patient and patients found them to be a very good way to find out about what had happened to them each day of their stay in the critical care unit without having to read through clinical terminology.

The practice educator had developed a ten-minute teaching break at 3pm each day (“TEA-ching”) where they would deliver a short teaching course or invite a member of hospital staff to speak about what they do, for example, the hospital chaplain.

Maternity

Facts and data about this service

The maternity unit at Wrightington, Wigan and Leigh NHS Foundation Trust is located on the Royal Albert Edward Infirmary site.

The maternity unit has an antenatal and postnatal ward with 28 beds including three single rooms. There is a dedicated triage unit with two assessment rooms and day assessment area with two couches within the maternity unit.

The labour ward has nine en suite birthing rooms including a pool room for women who choose to use water for pain relief in labour and or birth. The labour ward hosts a maternity operating theatre with an anaesthetic room and recovery area for emergency caesarean section births. Elective caesarean section (planned) births are performed in the general theatres, on the same corridor directly opposite the maternity unit. The neonatal unit is situated adjacent to the delivery suite and the high dependency unit is located on the same corridor directly opposite the labour ward doorway.

The trust has two offsite antenatal clinics; The Thomas Linacre Centre in Wigan and Leigh Infirmary; both clinics provide consultant and midwifery clinics.

Midwifery led antenatal care is additionally provided by the community midwives from four community teams at GP surgeries, children's centres or at a woman's home. The maternity service also supports women who choose to birth their baby at home.

A commissioned integrated public health team of midwives works alongside the community midwives providing care to the top 2% most vulnerable women in the borough during the antenatal and postnatal period.

The maternity unit currently holds UNICEF Baby Friendly Gold Accreditation and the hospital is a World Health Organisation Healthy Hospital site.

(Source: RPIR – Acute context tab)

From January 2018 to December 2018 there were 2,640 babies birthed at the trust.
(Source: trust data)

We inspected the maternity service as part of an unannounced inspection (they did not know we were coming) between 22 and 24 October 2019. We visited all maternity clinical areas on the main hospital site and also the elective obstetric theatres. We also visited the community midwives base and antenatal clinic at the Leigh infirmary site. As part of the inspection we reviewed information provided by the service about staffing, training and monitoring of compliance.

During the inspection we spoke with 78 members of staff including midwives of all grades including the head of midwifery and midwifery matrons, administration staff, obstetricians of all grades, maternity support workers, anaesthetists, scrub nurses, operating department practitioners, pharmacists and pharmacy technicians. We spoke with nine women who were using the service at the time of our inspection, six new dads and one relative. We reviewed fifteen prescription charts, fifteen sets of women's maternity records and a sample of 14 guidelines pertaining to maternity.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trust set a target of 95% for the completion of mandatory training.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified midwifery staff in maternity is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-fraud awareness	25	27	92.6%	95%	No
Blood collection	25	27	92.6%	95%	No
Blood transfusion	24	27	88.9%	95%	No
Bowel management programme	25	27	92.6%	95%	No
Conflict resolution	24	27	88.9%	95%	No
Dementia training	25	27	92.6%	95%	No
Emergency planning	24	27	88.9%	95%	No
Equality and Diversity	22	27	81.5%	95%	No
Fire safety	25	27	92.6%	95%	No
Health and Safety	25	27	92.6%	95%	No
Infection prevention		27	0.0%	95%	No
Information governance clinical	25	27	92.6%	95%	No
Medical devices	25	27	92.6%	95%	No
Medicine safety	25	27	92.6%	95%	No
Moving and handling clinical	25	27	92.6%	95%	No
Resuscitation	25	27	92.6%	95%	No
Safe Use of Insulin	24	27	88.9%	95%	No
Slips trips and falls clinical	24	27	88.9%	95%	No

In maternity the 95% target was not met for any of the 18 mandatory training modules for which qualified midwifery staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for medical staff in maternity is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-fraud awareness	15	18	83.3%	95%	No
Blood collection	15	18	83.3%	95%	No
Blood transfusion	15	18	83.3%	95%	No

Conflict resolution	16	18	88.9%	95%	No
Delirium	13	18	72.2%	95%	No
Dementia training	13	18	72.2%	95%	No
Emergency planning	15	18	83.3%	95%	No
Equality and diversity	15	18	83.3%	95%	No
Fire safety	16	18	88.9%	95%	No
Health and safety	13	18	72.2%	95%	No
Infection prevention		18	0.0%	95%	No
Information governance clinical	14	18	77.8%	95%	No
Medical devices	16	18	88.9%	95%	No
Medicine safety	15	18	83.3%	95%	No
Moving and handling clinical	15	18	83.3%	95%	No
Resuscitation	16	18	88.9%	95%	No
Safe use of insulin	12	18	66.7%	95%	No
Slips trips and falls clinical	15	18	83.3%	95%	No

Maternity specific training for medical staff including obstetricians and anaesthetists was 97% at the time of our inspection.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified midwifery staff in maternity is shown below:

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Vulnerable Adults	25	27	92.6%	95%	No
Prevent	22	27	81.5%	95%	No
Safeguarding Children Level 3	24	27	88.9%	95%	No

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in maternity is shown below:

The tables below include Prevent training as a safeguarding course. Prevent works to stop

individuals from getting involved in or supporting terrorism or extremist activity.

Training module name	April 2018 to March 2019				
	Staff trained /compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Vulnerable Adults	14	18	77.8%	95%	No
Prevent	13	18	72.2%	95%	No
Safeguarding Children Level 3	15	18	83.3%	95%	No

The department employed a safeguarding specialist midwife who provided regular safeguarding supervision and acted as a point of contact for all community midwives.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas of the maternity departments that we visited were clean and all equipment had “I am clean” notices placed on them.

The department had an infection prevention and control policy and we observed that the majority of staff fully adhered to this policy and its principles for preventing and managing infections by, for example, being bare below the elbows. However, during our inspection we observed that one staff member, part of the theatre team, wore nail polish that was not in line with this guidance. We raised this to the leadership team at the time of the inspection and were told that it had been remedied immediately.

All staff were encouraged to receive their seasonal flu vaccination to prevent them infecting the women and babies in their care. These were carried out by the trust’s occupational health department staff.

At the time of booking women were encouraged to receive the Pertussis (whooping cough) vaccine and, at the appropriate times, their seasonal influenza vaccines. These were administered either by midwives of their GPs.

There were washbasins with hand soaps in appropriate places in all clinical areas that we visited and we observed these being used by staff, women and their visitors.

There were hand sanitising gels placed appropriately in all clinical areas and we observed that they were used correctly by women, staff and visitors.

All sharps bins that we observed during our inspection were being used appropriately and we observed none that were filled above the recommended level.

Hand hygiene audits across the all of maternity services for September 2019 highlighted a compliance of 100%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

Staff were trained to use them. Staff managed clinical waste well.

All equipment had an individual asset number placed upon it and all had been serviced and calibrated accordingly. The service used an electronic system for tracking equipment. Any asset number could be inputted to highlight information such as when that particular piece of equipment was purchased, when the manufacturer's warranty expired and when it was next due for service.

All privacy curtains around clinical treatment areas and bed spaces were dated when they were due to be changed and staff told us that they would be changed sooner if soiled.

Entry to all clinical areas was via a controlled access system in order to monitor women, babies and visitors entering and leaving the premises. We were told that there had never been an attempted baby abduction from the unit. We were told of plans to consider a baby tagging system which would alarm if an attempt to remove a baby without authorisation was to occur.

The day assessment and triage unit consisted of two single rooms and a two bedded assessment area. Out of hours women were seen in two single rooms within the labour ward area. We were told that if a woman telephoned with a history of no fetal movements or heavy vaginal blood loss she would be asked to attend one of the rooms on the labour ward in case there was a poor prognosis. We were told by the matron that there were plans to move triage and the day assessment unit to the labour ward area permanently.

The department was developing a transitional care unit (an area that enables mum and baby to remain together but with additional support to help you care for your baby and feed them). At the time of our inspection this was being used as a transitional care bay but babies were still being taken to the neonatal unit for antibiotic medication. We were told that as from the Monday after our inspection (28 October 2019), there would always be a neonatal nurse assigned to work in that bay 24 hours per day, seven days per week, to prevent new mothers being separated from their babies. This would bring this service in line with national recommendations.

One five bedded bay on the antenatal/postnatal ward was used as an induction of labour bay. We were told of structural plans to move the wall and doors to one labour ward entrance so that this bay became part of the labour ward.

At the time of our inspection there was no designated midwife-led unit. However, during our inspection we were told of plans to convert to two side rooms with birthing pools into an 'alongside' midwife-led birthing suite, both with pools, for women who choose to birth their baby there.

At the time of our inspection the service did not have a 'standalone' midwife-led unit. However, during our inspection we were shown the location at Leigh Infirmary, and showed us the architects plans, for the development of two birthing rooms, both with pools, and a new community midwives office.

Once these two extra birthing choices are completed and opened women at this maternity unit will offer women the recommended four places of which to choose where to birth their baby which complies with national recommendations.

We visited the antenatal clinic at Leigh Infirmary. This consisted of a waiting area for women and their partners and five consulting rooms. At our last inspection we highlighted that there was limited or no access to a resuscitation trolley in the event of a maternal collapse. During this inspection we found that there was access to a resuscitation trolley that was located in the X-ray department along the corridor. Staff told us that they had been instructed to dial 999 and request an emergency paramedic to attend, to provide basic life support in the interim period and if deemed appropriate to send a member of staff to get the resuscitation trolley. This was in line with

their standard operating procedure for resuscitation. We reviewed the resuscitation departments risk assessment following our last inspection and it highlighted that “as there have been no incidents there is no requirement for a defibrillator or pocket mask”. However, step four of their risk reduction plan highlighted that “Leigh ANC (antenatal clinic) to obtain an Automated Defibrillator (AED) and a pocket mask to be made accessible for all staff in case of cardiac arrest within the department.” The date this had to be actioned by was 4/12/2019. We did not find this risk listed on the departments risk register.

In all of the five consulting rooms at Leigh Infirmary the department had installed a call bell system, which was an improvement since the last inspection. However, in one of these rooms there was an old style emergency call bell that may be used in any confusion during an emergency. We escalated this at the time of our inspection and were told that this would be removed immediately.

Assessing and responding to women and babies risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

The service used a modified early obstetric warning system to monitor, identify and act if women deteriorated. The service had guidelines which set out how and when to complete the charts. The service carried out monthly audits of compliance to ensure they were completed properly.

We saw evidence that women were risk assessed for potential conditions such as venous thromboembolism (blood clots) and allergies.

The service had recently reviewed staffing in theatres and we found they were working in line with guidance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

We reviewed 15 sets of women’s and babies’ records and noted that in one set of antenatal notes it had not been documented that the woman had been offered carbon monoxide screening and one woman had not been asked about domestic abuse.

Staff we spoke with were able to articulate the signs and symptoms of sepsis and what to do in the event of a suspected occurrence and used a validated sepsis screening tool to facilitate this.

The service used the gestational related optimal weight (GROW) package as a way of identifying babies that were not growing as they should before birth and there was a robust pathway for staff to follow if this was suspected. We observed personal growth charts that were completed correctly that ensued this process was being followed by maternity staff.

During our inspection we observed an elective caesarean section birth, with the woman’s consent. Prior to the woman being brought to the theatre area we observed a safety huddle where each case on that day was discussed, highlighting any special wishes of the woman and any risks. The WHO (World Health Organisation) surgical safety checklist was used throughout the procedures and as well as being documented on a board on the wall, it was also documented on the theatre information technology system which ensured that all sections were completed.

We saw evidence of the 58 current risk assessments that the maternity service had carried out to assess and mitigate risks to service users and staff.

Following the inspection we requested details of the WHO audits and will update this report when received.

Midwifery staffing

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

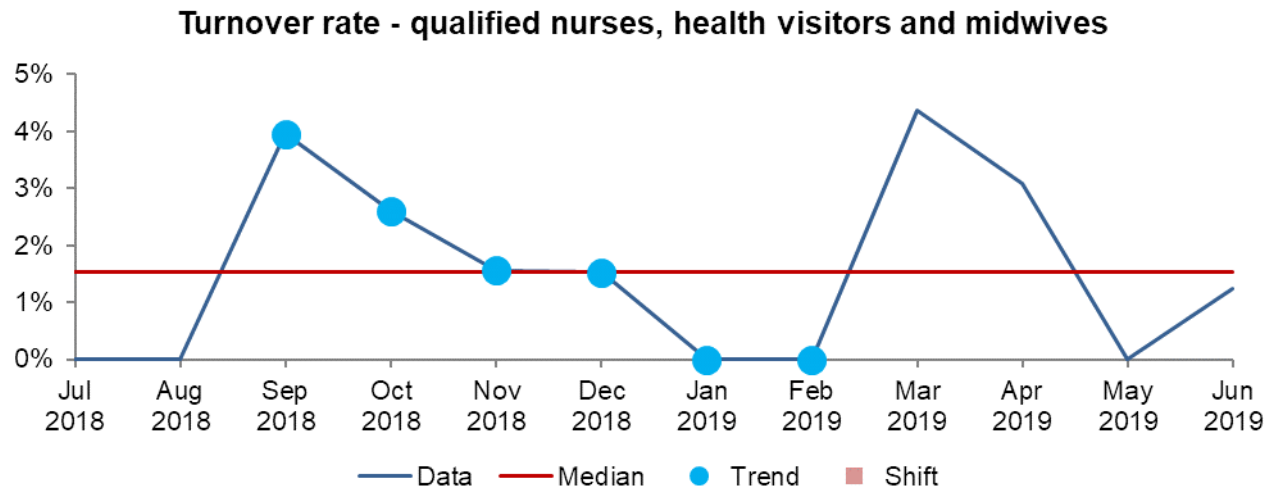
The table below shows a summary of the nursing staffing metrics in maternity at trust level compared to the trust's targets, where applicable:

	Maternity annual staffing metrics July 2018 – June 2019			
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**
Target		4%	9%	4.0%
All staff	214.4	1%	16%	4.8%
Qualified midwives	129.6	0%	18%	4.7%

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Staffing rates within maternity were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, sickness, bank and agency use.

Turnover rates



Monthly turnover rates over the last 12 months for qualified nurses, health visitors and midwives show a downward trend from September 2018 to February 2019.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Midwife to birth ratio

From January to December 2018 the trust had a ratio of one midwife to every 16.9 births. This

was much better than the England average of one midwife to every 24.6 births.

It was also an improvement from the previous period where the trust had a ratio of one midwife to every 18.7 births from January – December 2017.

(Source: Electronic Staff Records – EST Data Warehouse)

Data that we received following our inspection highlighted that between January 2019 and September 2019 the midwife to birth ratio was an average of one midwife to every 24.8 births. The department achieved a rate of 88.4% of women who received 1:1 care in labour for the same period. However, this had increased to 99.08% for the period September 2019.

At the time of the inspection the vacancy rate for midwives was 1.9 whole time equivalent whilst the rate for maternity support workers was 1.42 whole time equivalent. However, two maternity supports workers had been recruited meaning that when they started the vacancy rate would be 0.14 whole time equivalent. This was an improvement from the last time that we inspected this service.

We observed a 'comm [communication] cell' meeting during our inspection at the morning handover of midwives from the night shift to the day staff. All midwives and maternity support workers that were coming on for the day shift attended along with a representative from each clinical area. We observed that the acuity of each clinical area in maternity, such as elective caesarean section and inductions of labour were discussed and then staff were moved to assist in areas that required assistance.

The service used a recognised acuity tool to continually monitor that they had the correct number of staff in each clinical area.

Staff we spoke with told us they felt able to escalate any staffing concerns to the maternity manager on call at any time, day or night.

Community midwives we spoke with told us their caseload of women that they are the named midwife for at any one time was 95 per whole time equivalent.

Medical staffing

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

The table below shows a summary of the medical staffing metrics in maternity at trust level compared to the trust's targets, where applicable:

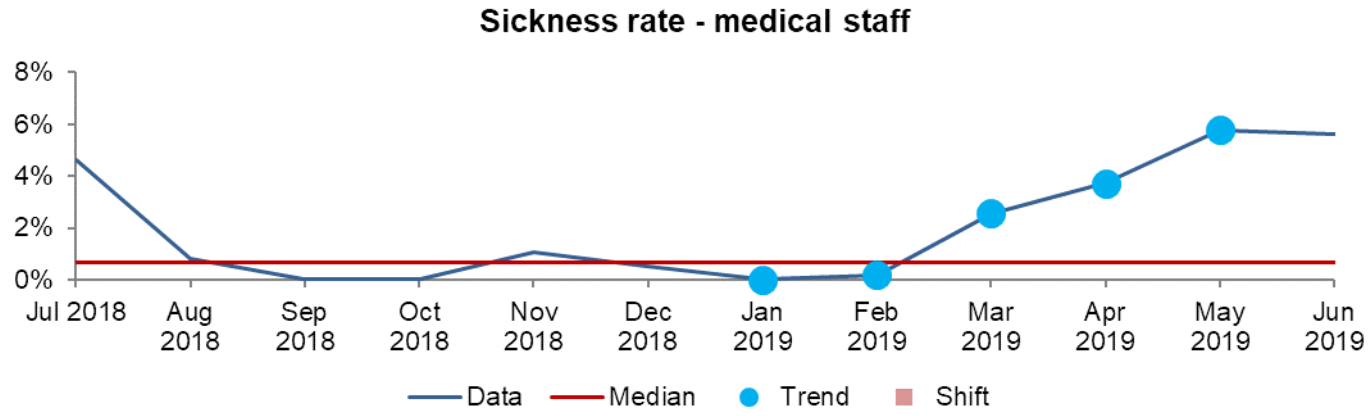
	Maternity annual staffing metrics						
	July 2018 – June 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available**	**Annual locum hours (% of available**	**Annual unfilled hours (% of available**

					hours)	hours)	hours)
Target		4%	9%	4.0%			
All staff	214.4	1%	16%	4.8%			
Medical staff	31.4	-1%	6%	2.1%	634		

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within maternity were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, bank and locum use.

Sickness rates



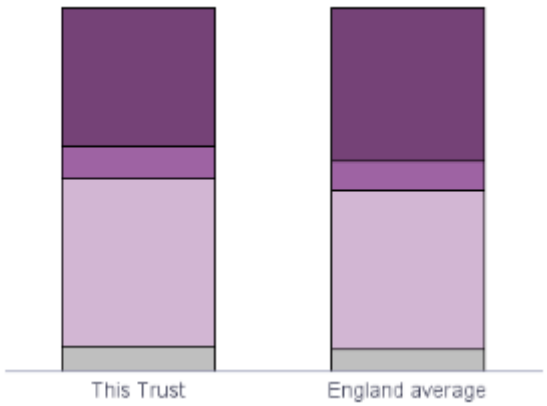
Monthly sickness rates over the last 12 months for medical staff shows an upward trend from January 2019 to May 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Staffing skill mix

In May 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was similar to the England average.

Staffing skill mix for the 29.2 whole time equivalent staff working in maternity at Wrightington, Wigan and Leigh NHS Foundation Trust.



	This Trust	England average
Consultant	38%	42%
Middle career^	9%	9%
Registrar group~	46%	44%
Junior*	7%	6%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)
There was 24 hours, seven days per week access to an obstetric anaesthetist on call.

There was 60 hours per week consultant obstetrician presence on the labour ward and there was always consultant cover outside of these hours.

The service had a duty had a duty anaesthetist providing 24 hours a day, seven days a week cover and was immediately available.

The service had 10 consultant sessions per week to cover emergency work on the delivery suite in line with the Guidelines for the Provision of Anaesthetic Services (GPAS), Consultant Responsibilities. If there was no consultant rostered for the labour ward because of holidays, study leave or sickness, then the "starred" consultant or the consultant in the emergency theatre was available for help.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The maternity department used a combination of paper based records and a maternity information system.

We observed that women's and babies' records were always locked securely in keypad accessible cabinets when not being used.

Cardiotocograph readings, a print out of the fetal heart in the antenatal and intrapartum period, were stored securely within the woman's notes. They were all labelled correctly and had been peer reviewed periodically in line with national recommendations.

We reviewed 15 sets of maternity notes and observed that, whilst all 141 antenatal contacts had been dated, only 77 had the time of the contact documented.

We reviewed 15 prescription charts and, of those, nine did not have the woman's weight documented upon them. We were told that their guideline stated that the process was to use the booking weight. We asked six members of staff, separately, including two midwives, two pharmacists and two obstetricians about the prescribing medications to prevent venous thromboembolic events (VTEs) and all of them went straight to the antenatal booking notes for the booking weight to ascertain the correct dosage. Following the inspection, we reviewed their guideline for this and this validated that they were following their own guidelines.

Medicines

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

The temperature of the medication fridges, and the rooms in which they were kept, were checked daily and documented.

We saw documented evidence that where a fridge temperature had exceeded its recommended maximum temperature all of the medications contained within were disposed of and replaced.

At our last inspection in November 2017 we told the service that it must ensure that administration of diamorphine on the ward followed their guidelines and that and babies were monitored appropriately. The maternity service developed a new guideline to ensure compliance with this. Two audits looking at compliance with this new guideline had been carried out highlighting 100% compliance with this new system. This was an improvement since our last inspection.

The department had a dedicated pharmacist and pharmacy technician who we observed working in the clinical areas. They told us they oversaw medications and prescriptions in the maternity area to ensure compliance and safety.

The department did not facilitate self-medication for women using the maternity service.

We reviewed the controlled drugs and their storage cupboards and documentation. All were in order and appropriately stored within locked cupboards in locked rooms.

All of the medications that we checked during our inspection were in date to be used safely as per manufacturers' recommendations.

Incidents

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

Never events

From August 2018 to July 2019 the trust reported no incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from August 2018 to July 2019.

All three incidents were classified as maternity/obstetric incidents meeting SI criteria: baby only (this include foetus, neonate and infant). The incidents all relate to the babies being born in poor conditions, and in two of which the babies subsequently died.

(Source: Strategic Executive Information System (STEIS))

Following the inspection we requested the incidents from the previous twelve months and will update this report as and when we receive it.

All of the staff we spoke with were aware of what incidents to report and how to report them.

All of the staff we asked were able to verbalise an instance of learning from an incident and said they always received feedback when they reported an incident.

We observed on the 'comm cell' wall where learning from incidents were highlighted for all staff to read.

We reviewed the most recent incident reports from July to September 2019 and the highest type was post-partum haemorrhage greater than 1,500 millilitres followed by unexpected admissions to the neonatal unit. This highlighted a good reporting culture following such incidents and good investigation and learning which was disseminated to staff in a variety of formats.

The service had monthly workshops where specific teaching would take place, such as diabetes in pregnancy following an incident.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

During the inspection we did not see any evidence of the maternity dashboard that was accessible for service users. We raised this to the head of midwifery and before the inspection was complete, copies of the maternity dashboard were visible in all clinical areas.

Is the service effective?

Evidence-based care and treatment

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

During our inspection we reviewed 14 guidelines used in the maternity service and all were within date and evidence based.

The department employed a cardiotocograph midwife for one day per week to facilitate group and individualised training to promote evidence based practice.

The service had carried out an audit between January and March 2019 into cardiotocograph usage during labour. Of the instances where there were concerns these were found to be escalated to an appropriate health professional and the subsequent plan was followed in 100% of cases.

Following the inspection, we requested details of audits carried out by the department in the 12 months before our inspection. We were sent details of audits which covered subjects such as induction of labour, GAP and GROW and emergency caesarean section. We found that these were carried out using robust processes and highlighted both good practice, compliance and areas for improvement.

We reviewed the induction of labour audit which was reviewed and benchmarked in March 2018 and found it to be in date and in line with national recommendations.

There were specific care pathways for women with reduced fetal movements to standardise and improve care provision to all women.

We saw evidence that the service was actively involved with other maternity services in their geographical area to standardise and benchmark their care provision.

The unit had implemented the Perinatal Institute's gestational related optimal weight (GROW) package which is an evidence based programme which supports the detection of small for gestational age babies. Women identified in the antenatal period of measuring small for dates would be recommended to receive a growth scan and, if necessary, an obstetric review. To meet the increased capacity for ultrasound scanning that this had resulted in, the service had already trained one of their midwives, and were in the process of training a second to carry out third trimester ultrasound scans.

Women who were deemed as being low risk for complications and were able to have their labour induced at the hospital and then return home to await events.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Women told us that staff gave them sufficient food and drink to meet their needs.

Cold drinks trolleys were available free of charge in all clinical areas for women and their partners to help themselves, 24 hours per day, seven days per week.

Tea and coffee was offered to all women and their partners at regular intervals throughout the day. Women were able to ask for a hot drink in between times.

The service has achieved gold standard with the UNICEF breast feeding accreditation scheme.

During the period January 2019 to September 2019 inclusive 49.5% attempted initiation of breastfeeding or gave their baby expressed breastmilk. This had improved to 52.6% by the time of our inspection.

The service employed two whole time equivalent breastfeeding specialist midwives.

We were told that there were some breastfeeding volunteers that assisted women. However, we did not observe these during our inspection.

Women that we spoke with told us that there was always help available for infant feeding.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Women had access to epidural anaesthesia during their labour 24 hours per day, seven days per week.

Alternative forms of pain relief were available for women to use such as the birthing pool on the labour ward.

We were told of plans to create an alongside birthing suite with two rooms, both with pools. We were also shown plans for the freestanding birthing suite and its two rooms, also with two pools. Both of these planned improvements would increase women's options for this form of pain relief.

All of the women that we spoke with during our inspection told us that they were offered, and received pain relief, in a timely way.

The department carried out two induction of labour records audits that included reviewing appropriate pain relief administration. This highlighted that all women whose labours were induced were receiving the correct medication, in the correct place in a timely way.

Women and babies outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

National Neonatal Audit Programme

The table below summarises Royal Albert Edward Infirmary's performance in the 2018 National Neonatal Audit Programme against measures related to maternity care.

Metrics *(Audit measures)*	Hospital performance	Comparison to other hospitals	Meets national standard?
Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids? (*Antenatal steroids reliably reduce the chance of babies developing respiratory distress syndrome and other complications of prematurity)*	91.7%	Better than expected	Met

Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery? *(Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later develop cerebral palsy)*	61.5%	Similar	No current standard

The trust has seen an improvement in performance in both metrics from the 2017 audit.

For the question: Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

In the 2017 NNAP audit the trust scored 85.9%, this has increased to 91.7%.

For the question: Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

In the 2017 NNAP audit the trust scored 18.2%, this has increased to 61.5%.

(Source: National Neonatal Audit Programme)

National Maternity and Perinatal Audit Programme

The table below summarises Royal Albert Edward Infirmary's performance in the 2017 National Maternity and Perinatal Audit Programme against measures related to maternity care.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other hospitals**	**Meets national standard?**
Trust-level case ascertainment* (*Proportion of eligible cases included in the audit)*	104.3%	N/A	Met
Antenatal measures (*before birth, during or relating to pregnancy)*			
Case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date *(Babies who are small for their age at birth are at increased risk of problems before, during and after birth)*	40.0%	Lower than expected	No current standard
Intra-partum measures (*during labour and birth)*			
Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery (*For babies with a planned (or elective) birth, being born before 39 weeks is associated with an increased risk of breathing problems. This can lead to admission to the neonatal unit. There is also an association with long term health and*	12.4%	Lower than expected	No current standard

behaviour problems)			
Case-mix adjusted overall caesarean section rate for single, term babies (*The overall caesarean section rate is adjusted to take into account differences which may be related to the profile of women delivering at the hospital)*	26.9%	Within expected range	No current standard
Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7 (*The Apgar score is used to summarise the condition of a newborn baby; it is not always a direct consequence of care given to the mother during pregnancy and birth, however a 5 minute Apgar score of less than 7 has been associated with an increased risk of problems for the baby)*	1.8%	Within expected range	No current standard
Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear (*Third or fourth degree tears are a major complication of vaginal birth. Only tears that are recognised are counted therefore a low rate may represent under-recognition as well as possible good practice)*	4.0%	Within expected range	No current standard
Case-mix adjusted proportion of women with severe post-partum haemorrhage of greater than or equal to 1500 ml (*Haemorrhage after birth is a major source of ill health after childbirth. Blood loss may be estimated by visual recognition or by weighing lost blood. High rates may be due to more accurate estimation and low rates due to under recognition)*	3.2%	Within expected range	No current standard
Post-partum measures (*following birth)*			
Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit (*Breastfeeding is associated with significant benefits for mothers and babies. Higher values represent better performance)*	52.5%	Bottom 25% of hospitals	No current standard

* This metric shows the proportion of eligible cases within the hospital that were submitted to the audit. The comparison is made against Hospital Episode Statistics data. Case ascertainment describes the proportion of births for which data were received, compared to the total number of births recorded through HES. This can sometimes be higher than 100% due to inconsistencies in local coding methodologies.

(Source: National Maternity and Perinatal Audit Programme)

Standardised Caesarean section rates and modes of delivery

From January to December 2018 the total number of caesarean sections and the standardised caesarean section rates for elective and emergency sections were all similar to expected.

Type of caesarean	England	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST			
	Caesarean rate	Caesareans (n)	Caesarean rate	Standardised Ratio	National comparison
Elective caesareans	12.8%	334	12.6%	119.6	Similar to expected
Emergency caesareans	16.5%	419	15.8%	83.4	Similar to expected
Total caesareans	29.3%	753	28.5%	98.5	Similar to expected

Source: Hospital Episode Statistics, January 2018 to December 2018

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.
Delivery methods are derived from the primary procedure code within a delivery episode.
This table includes all deliveries, including where the delivery method is 'other' or 'unrecorded'.
To protect patient confidentiality, trust figures and percentages between 1 and 7 have been suppressed and replaced with "" (an asterisk) where necessary. Values greater than 7 rounded to the nearest 5 with the delivery rate calculated with the rounded figures.*

In relation to other modes of delivery from January to December 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

Proportions of deliveries by recorded delivery method (January 2018 to December 2018)			
Delivery method	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Total caesarean sections[1]	753	28.5%	29.3%
Instrumental deliveries[2]	297	11.25%	12.3%
Non-interventional deliveries[3]	1,590	60.22%	58.4%
Total deliveries	2,640	100%	100%

Source: Hospital Episode Statistics, January 2018 to December 2018 (n=581,697)

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.
1Includes elective and emergency caesareans
2Includes forceps and ventouse (vacuum) deliveries
3Includes breech and vaginal (non-assisted) deliveries

To protect patient confidentiality, trust figures and percentages between 1 and 7 have been suppressed and replaced with "" (an asterisk) where necessary. Values greater than 7 rounded to the nearest 5 with the delivery rate calculated with the rounded figures.*

Total caesarean sections at the trust were slightly lower than the England average, whilst non-interventional deliveries were slightly higher than the England average.

(Source: Hospital Episode Statistics (HES))

The service were carrying out regular audits and reviews of emergency caesarean section birth in an attempt to highlight any areas for improvement. No themes had emerged at the time of our inspection.

Maternity active outlier alerts

As of August 2019, the trust had no active maternity outliers.

(Source: Hospital Evidence Statistics (HES)

MBRRACE-UK Perinatal Mortality Surveillance Report

The table below summarises the trust's performance in the 2018 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2016.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other trusts with similar service provision**	**Meets national standard?**
Stabilised and risk-adjusted perinatal mortality rate **(***The death of a baby in the time period before, during or shortly after birth is a devastating outcome for families. There is evidence that the UK's death rate varies across regions, even after taking into account differences in poverty, ethnicity and the age of the mother.)*	4.87	Up to 10% higher than the average for the comparator group	No current standard

Trust performance has declined from the previous year (2017 report for births in 2015).

In the 2017 report, the stabilised and risk-adjusted perinatal mortality rate was 4.59, which was up to 10% lower than the average for the comparator group.

(Source: MBRRACE-UK)

In November 2019 the service was setting up a continuity of carer team. Research has highlighted that this model of care reduces the incidence of stillbirth.

In the period January 2019 to September 2019 inclusive there were 1,874 registerable births. Of these, 1.2% of women required readmission within 30 days of their birth and 36.2% had their labour induced. In the same period 13.5% of women birthed their baby by elective caesarean section and 18.4% birthed their baby by emergency caesarean section.

In the period January 2019 and September 2019 inclusive there were 15 planned home births, no maternal deaths and eight stillbirths. There were 30 third and fourth degree tears and 206 operative vaginal births.

Competent staff

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

Appraisal rates

Trust level

From April 2018 to March 2019, 75.5% of required staff in maternity received an appraisal compared to the trust target of 90%.

Only the healthcare scientists group met the 90% target.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received appraisal	Eligible staff	Completion rate	Trust Target	Met (Yes/No)
Administrative and clerical	16	18	88.9%	90%	No
Nursing and midwifery registered	116	137	84.7%	90%	No
Additional clinical services	27	36	75.0%	90%	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

All of the staff that we spoke with during our inspection told us that they had had their appraisal within the previous 12 months. Therefore, we have requested up to date appraisal rates and will update this report as and when received.

During the inspection we spoke with several student midwives at differing stages of their training who all told us that they were well supported in their learning with mentors and other staff.

Newly qualified midwives told us that they were given a good preceptorship package that supported their learning and consolidation of their skills.

The trust did not hold medical staff appraisal data specifically broken down to maternity so we have been unable to include medical staff appraisal rates in the table above.

The service provides human factors training for all staff to promote safe care provision.

We observed documented evidence that the department facilitated regular ad hoc training in the hospital that was well attended by the multidisciplinary teams. These included obstetric emergency scenarios such as post-partum haemorrhage and shoulder dystocia and sepsis.

We saw documented evidence that some obstetric emergencies training in the home birth setting had taken place and was well attended by community midwives.

The cardiotocograph midwife had weekly dedicated time for giving training to midwives and doctors.

Multidisciplinary working

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

Most of the multidisciplinary team, which included midwives, anaesthetists, theatre staff and neonatal staff involved in women's and babies' care attended a daily morning meeting to discuss women in their care and worked together to achieve optimum care provision. However, we noted

that obstetricians did not attend this meeting.

The service worked with the local council to fund three specialist midwives to care for the top two percent of women who are considered to require complex care.

The service told us that on the Monday following our inspection the maternity staff and neonatal staff would commence facilitating a transitional care unit within the maternity ward to reduce the incidences where babies that require specialised neonatal care were separated from their mothers.

We were told, and observed during our inspection, that there was good multidisciplinary teamwork between midwives, obstetricians and all other staff involved in the provision of maternity care.

Seven-day services

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

Maternity services were available 24 hours per day, seven days per week. Midwifery, obstetric and anaesthetic cover was provided outside of these normal working hours and midwifery staff told us that they felt supported to provide good care by other members of the maternity team outside of normal hours.

Women could self-refer to the midwifery triage service at any time of the day or night, seven days per week, if they had any concerns during their pregnancy.

Health promotion

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

The service employed two whole time equivalent infant feeding specialist midwife.

We saw evidence that women were offered screening for carbon monoxide at appropriate times during their pregnancy and offered referral to the smoking cessation service if required.

At the booking appointment all women were advised of the recommendation to be administered the Pertussis (whooping cough) vaccine and, at specific periods in the year, the influenza vaccine.

Between January 2019 to September 2019 90.15% of baby's birthed in the unit received skin to skin care within one hour of their respective birth.

The maternity unit staff had access to nicotine replacement therapy for women that smoked to use whilst staying in the hospital as the whole site was a no smoking area.

Safe sleeping to prevent cot death was discussed by midwives at appropriate times during their pregnancy journey.

We observed posters around the unit promoting skin to skin and also that "dad matters".

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Trust level

The trust set a target of 95% for the completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training modules from April 2018 to March 2019 at trust level for qualified midwifery staff in maternity is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	24	27	88.9%	95%	No

In maternity the target was not met for either of the two Mental Capacity Act training modules for which qualified midwifery staff were eligible.

A breakdown of compliance for MCA/DOLS training from April 2018 to March 2019 trust level for medical staff in maternity is shown below:

Training module name	April 2018 to March 2019				
	Staff trained /compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	10	18	55.6%	95%	No

In maternity the target was not met for the Mental Capacity Act training module for which medical staff were eligible.

We have requested updated mandatory training figures and will update as and when received.

Staff that we spoke with during our inspection were aware of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005**.**

Women using the service were asked about their mental wellbeing at appropriate times during their pregnancy.

Where a history of mental illness was identified, there was a clear pathway for their care prior to the birth and in the postnatal period.

In the 15 sets of records that we reviewed both verbal and written consent had been obtained and documented where appropriate.

Is the service caring?

Compassionate care

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

All of the women, their partners and relatives we spoke with during our inspection described the care from midwifery and obstetric staff as good and great.

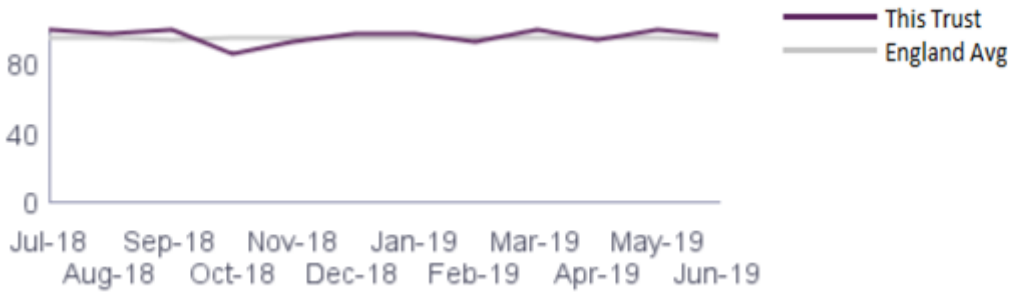
The department was due to open a transitional care bay on the postnatal ward the Monday following our inspection. This would mean parents being able to stay with their baby whilst receiving specialist care from midwifery and neonatal staff.

The department told us that they were in the process of developing a rainbow clinic which is a clinic where women who had a previous stillbirth or neonatal loss received specialist care to prevent further loss.

Women that we spoke with during our inspection described the midwives that cared for them as “angels” and “supportive”.

Friends and Family test performance

Friends and family test performance (antenatal), Wrightington, Wigan and Leigh NHS Foundation Trust

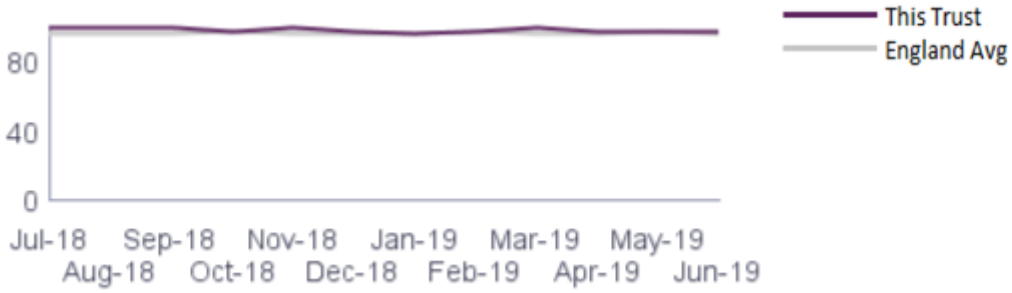


From July 2018 to June 2019 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

Trust performance ranged from 86% (October 2018) to 100% compared to the England average, which was 95% for all months except one.

The trust scored 100% recommended in four months in the period, September 2018, March 2019, May 2019 and July 2019.

Friends and family test performance (birth), Wrightington, Wigan and Leigh NHS Foundation Trust



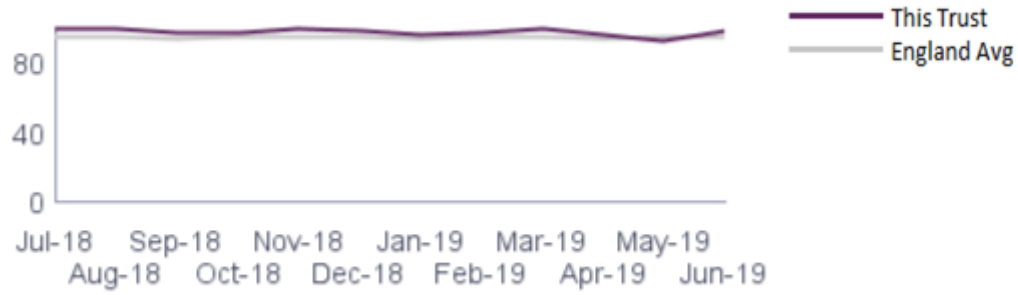
From July 2018 to June 2019 the trust’s maternity Friends and Family Test (birth) performance

(% recommended) was generally similar to the England average.

Trust performance ranged from 97% to 100% compared to the England average, which ranged from 96% to 97%.

The trust scored 100% recommended in five months in the period, July, August, September and November 2018, and March 2019.

Friends and family test performance (postnatal ward), Wrightington, Wigan and Leigh NHS Foundation Trust



From July 2018 to June 2019 the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

Trust performance ranged from 93% to 100% compared to the England average, which ranged from 94% to 95%.

The trust scored 100% recommended in four months in the period, July, August and November 2018 and March 2019.

Friends and family test performance (postnatal community), Wrightington, Wigan and Leigh NHS Foundation Trust

From July 2018 to June 2019 the trust only had one month (March 2019) in which data was available for the Friends and Family Test (postnatal community) performance (% recommended). In this month the trust scored 100% compared to the England average of 98%.

(Source: Friends and Family Test – NHS England)

CQC Survey of women's experiences of maternity services 2019

The trust performed better than other trusts for two of 19 questions in the CQC maternity survey 2019:

Thinking about your care during labour and birth, were you involved in decisions about your care?

Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

The trust performed about the same as other trusts for the remaining 17 questions.

Area	Question	Score	RAG
Labour and birth	At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	9.1	About the same
	During your labour, did staff help to create a more comfortable atmosphere for you in a way you wanted?	8.5	About the same
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	8.6	About the same
	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.7	About the same
Staff during labour and birth	Did the staff treating and examining you introduce themselves?	9.3	About the same
	Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	7.9	About the same
	If you raised a concern during labour and birth, did you feel that it was taken seriously?	9.1	About the same
	During labour and birth, were you able to get a member of staff to help you when you needed it?	9.3	About the same
	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.6	About the same
	Thinking about your care during labour and birth, were you involved in decisions about your care?	9.2	Better
	Thinking about your care during labour and birth, were you treated with respect and dignity?	9.7	About the same
	Did you have confidence and trust in the staff caring for you during your labour and birth?	9.4	About the same
	After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	7.8	About the same
Care in hospital after the birth	On the day you left hospital, was your discharge delayed for any reason?	5.6	About the same
	If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?	8.4	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	8.7	Better
	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	9.0	About the same
	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?	5.9	About the same
	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	9.3	About the same

(Source: CQC Survey of Women's Experiences of Maternity Services 2019)

Emotional support

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

We observed maternity staff providing reassurance to women and their partners as required.

Women were asked about their mental health wellbeing at appropriate times during their pregnancy journey.

Since our last inspection the department had employed a bereavement midwife to facilitate specialist care for women and their partners experiencing a pregnancy loss.

The department had recently held its first annual remembrance service for parents whom had lost a baby, which was held in the hospital chapel.

We were told of plans for a support group network for bereaved parents.

During our inspection there was an obstetric emergency that maternity staff dealt with appropriately. Immediately following this we noted that all staff concerned were asked to attend a team debrief where support could be given.

Understanding and involvement of patients and those close to them

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

We observed, and were told by women and those close to them, that staff spoke to women and their families sensitively and appropriately according to their individual needs and wishes.

We observed staff involving women and those close to them in decisions about their care and treatment.

Women and their partners told us they received relevant information in a way they understood. Partners were encouraged to be present at all maternity care when the woman wished this.

Staff respected women’s choices and delivered their care in an individualised, woman centred approach.

Is the service responsive?

Service delivery to meet the needs of local people

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

The service had plans to provide the four places of birth choices for their woman, which was a national recommendation. These are a consultant led unit, an alongside birthing centre, a standalone birthing centre or a home birth. The department will be one of a minority of maternity departments to offer all four choices to women when implemented. The plans for the alongside midwifery led unit were in the discussion stages, whereas the freestanding midwifery led unit plans already had funding agreed and we were shown architectural plans that would be followed once building work commences.

There were specialist midwives in place to facilitate tailored care to women and their babies with specific needs such and circumstances such as bereavement, safeguarding and infant feeding.

The department employed a specialist bereavement midwife to support women whose baby had died either during pregnancy or shortly afterwards. This was an improvement since their last inspection. There was one room within a quiet area of the labour ward specifically where women and their partners who had suffered a pregnancy loss would be cared for. The room was furnished with bedroom furniture and equipment to enabled mum and baby to stay together with their baby for as long as they wished in a private, quiet, homely environment. We were shown baby clothes in all sizes that parents were free to use to dress their baby and take keepsake photographs if they wished. We were told that the money for many of these furnishings and clothing had been raised by parents who had already used the room. Women did not birth their baby in this room, they were taken to one of the labour ward rooms for the birth then brought back to the room for the postnatal period.

Staff working within the service shared a common goal of excellent, woman centred care promoting women's choices. For example, whilst the maternity service currently only offered two places of birth, there were plans in place to increase this to four as recommended.

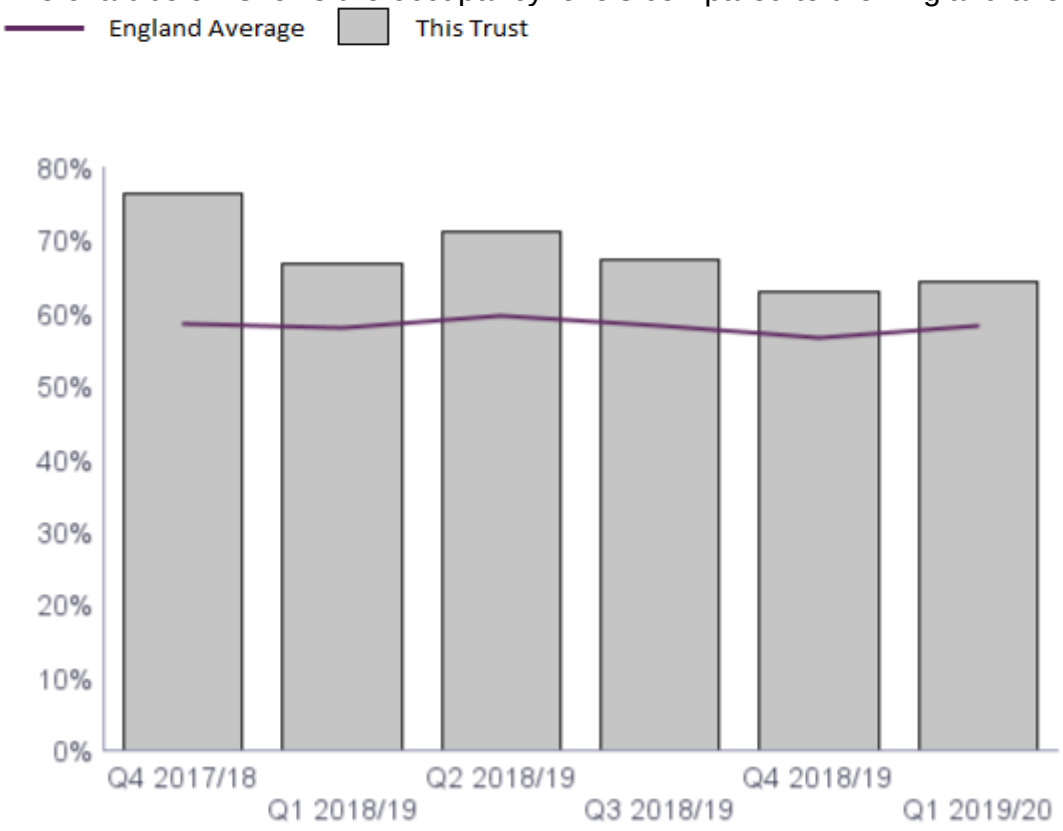
The service was working towards implementing a continuity of carer model of midwifery care in line with the recommendations from Better Births (2016). Evidence highlights that this may reduce the incidence of stillbirth and increase maternal satisfaction.

The department facilitated specialist clinics for women such as women with high risk medical conditions and vaginal birth after caesarean (VBAC) birth.

Bed Occupancy

From Q4 2017-18 to Q1 2019-20 to June 2019 the bed occupancy levels for maternity were generally higher than the England average, with the trust having 64.3% occupancy in Quarter 1 2019/20 compared to the England average of 58.4%

The chart below shows the occupancy levels compared to the England average over the period.



(Source: NHS England)

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers. One example of this was the 15 steps to maternity where we saw that the departmental leads had listened and responded to what the service users had said.

Women that were deemed to be in the top two percent of those with complex social issues such as safeguarding or mental ill health were cared for by the specialist public health midwives. This was a joint collaboration between the maternity department and the local council. The focus of their work was towards women who may be able to make a change and keep their baby. There were four midwives and one whole time equivalent maternity support worker within this team

There was a system in maternity staff to access a translator for women whose first language was not English.

Staff were able to access maternity leaflets in languages other than English to distribute to those for whom English was not their first language.

We observed that women birthing their baby by caesarean section were asked if they had any special wishes such as skin to skin with their baby immediately following the birth and their wishes were respected and carried out.

The department facilitated a "fifteen steps to maternity" (a toolkit that supports collaborative working between professionals and service users using, reviewing, designing and delivering maternity services) exercise with their maternity voices partnership. We saw that potential issues raised were responded to and, where appropriate, actioned by the maternity department. One

example of this was not all chairs for use by partners were reclining. The maternity leadership team responded by purchasing new reclining chairs for all rooms.

The staff of the maternity and critical care department had worked together to enable new mums and babies to have skin to skin when was receiving care in the critical care department. We observed an example of this during our inspection.

The department had recently introduced a continuity of carer team that met the women scheduled for an elective caesarean section prior to the birth, went into theatre with them for the birth and then cared for them in the immediate postnatal period.

We observed that the department had baby cots that fixed to the side of their mums bed to facilitate safe sleeping.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

The day assessment unit used an appointment system whereby women who needed to be reviewed, such as for a cardiotocograph for fetal wellbeing, were given an appointment time and day to attend.

At the time of our inspection the department had trained one midwife to provide third trimester scanning, and was currently training another, as they had recognised that there had been an increase in the needs for reassurance ultrasound scans in an initiative to reduce small for gestational age and stillborn babies. By having midwives trained to perform these scans it meant that more women would be seen in a more timely way.

The service had a system in place for women who did not attend for their appointment. There was a policy in place that highlighted what staff should do including considering safeguarding action if necessary. Staff were able to articulate what they would do in such circumstances.

We were told by staff that there had been instances where there had been a delay in waiting times for an obstetric review for women using the day assessment unit or triage when the unit was busy. During our inspection we did not observe any delays. However, the staff were not aware of any audits that would reassure them of how long women were waiting prior to discharge.

In the 12 months prior to our inspection the service was placed on divert (where arrangements had been put in place for women to attend a nearby maternity service) four occasions for periods of between four hours and 15 hours and 40 minutes. These were due to capacity and acuity of the service.

Learning from complaints and concerns

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

Summary of complaints

Trust level

From July 2018 to June 2019 the trust received 15 complaints in relation to maternity (2.9% of total complaints received by the trust).

The trust's complaints and concerns standing operating procedure sets out the different timescales for responding to complaints depending on the complexity of the complaint and issues raised. The agreed response times are 30 days, 40 days, 60 days or 90 days. The trust took an average of 31.4 working days to investigate and close complaints.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	10	66.7%
Values and behaviours (staff)	4	26.7%
Communications	1	6.7%
Total	**15**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From July 2018 to June 2019 there were 222 compliments received for maternity at the trust (7.1% of all received trust wide).

A breakdown of compliments by type and ward area is shown below:

Ward/ Area	Beverages	Biscuits	Chocolates	Donation	Misc	Card/ Letter Thank You	E-mail Thank you	Phone Thank you	Total
Community Midwifes	4	8	12		1	26		1	**52**
Delivery Suite	1	4	6	1	2	9	2		**25**
All maternity Service	11	24	31	27	7	39	6		**145**
Total	16	36	49	28	10	74	8	1	**222**

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Staff we spoke with told us complaints were shared with them in a variety of ways such as the 'comm cell' and emails.

We saw that compliments were fed back individually to the staff concerned and general comments from women and their families were displayed on boards in the clinical areas where staff and service users were able to read them.

Is the service well-led?

Leadership

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

There was a clearly defined management and leadership structure in place. We observed, and were told of, joint working between leaders both within the department, the rest of the trust and with external agencies and bodies to maximise care provision for women and babies.

The head of midwifery was supported in her role by dedicated midwifery matrons and band seven lead midwives.

There was a 24 hour per day, seven days per week manager on call for the maternity department and staff that we spoke with told us that they felt able to access at any time.

Staff we spoke with felt that the head of midwifery and other midwifery leaders were visible, approachable and supportive.

The ward leaders told us they were given protected time to carry out their leadership duties. This was an improvement since our last inspection.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

At the time of our inspection the department's vision was strongly aligned with that of the trust's vision.

The maternity department was developing a maternity specific vision, which would remain in line with that of the trust's, which was being developed with input from staff and service users.

The service was working towards achieving the recommendations highlighted within Better Births (2016) which included continuity of carer and multi-disciplinary training.

The service was working towards providing women with the recommended four options to birth their baby.

Culture

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

Staff told us this was a good place to work and that the culture of the unit was good. Staff told us there had been a noticeable improvement since the appointment of the new head of midwifery.

Student midwives, newly qualified midwives and trainee obstetricians told us that they were immediately made to feel welcome, part of the team and valued.

We observed, and saw evidence of, good working between all maternity staff irrespective of their grade or profession.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a lead midwife and obstetrician for governance in the department.

We reviewed guidelines and policies for the department as part of our inspection that were available electronically to all staff to access when they needed. We found that they were all within date.

We met with the departments triumvirate who told us that the three of them met regularly to discuss development of their maternity service and any issues. However, we were told that this meeting was not a regular scheduled meeting. Rather, they would meet on an ad hoc basis. Furthermore, they did not have an agenda or take minutes to evidence that they met.

We reviewed minutes of the maternity departmental meetings that were held monthly and found these to be well attended by representatives of the multidisciplinary team and appropriate discussion were held and actioned such as the risk register, staffing and concerns.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

We found that all of the staff that we asked during our inspection were aware of the risks on the risk register that were pertinent to their clinical area.

The service had clear documented escalation processes in place for incidents such as staffing shortages which may have affected women's and babies' safe care provision and staff were able to articulate these processes.

We saw evidence that incidents were shared with all staff on notice boards such as the comm cell, where all staff coming on duty at the start of each shift met to receive handover and updates and incidents within the department.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Ward boards, upon which a summary of women's and babies' personal details were documented, were placed in offices and were accessible only to authorised maternity staff.

At the start of our inspection we did not observe any copies of the maternity dashboard on the walls of the maternity department that were accessible to the service users or public. We mentioned this to the head of midwifery during our inspection and this was rectified immediately.

The service collected data to populate their dashboard with monthly figures and colour coded them to easily see where they were complying with local and national targets and whether they were

improving, staying the same or getting worse. These included induction of labour and third and fourth degree tear rates. We have requested the most up to date copy of this and will update the report as and when we receive it.

Engagement

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

Staff told us that they were encouraged and supported to develop their careers. Furthermore, staff told us that when they had an idea to implement a new initiative they were encouraged and supported to implement this. Examples given were the 'comm cell' and emergency trolley system on the labour ward.

The service worked with commissioners to facilitate their local maternity voices partnership where women and partners are invited to provide feedback to help share future maternity provision at the trust. One example of this is the fifteen steps to maternity exercise which was highlighted in the responsive section of this report with which the maternity departments leadership worked with service users and maternity service commissioners to provide the type of maternity service that women want for the future.

The service actively sought feedback from service users and, where appropriate, changed practice as a result. One example of this that we saw evidence of was that the department always had a protected mealtime policy which meant that no visitors were allowed during mealtimes. However, after listening to the women the service now permits partners into the unit during mealtimes and they care for their baby whilst their partner eats her meal whilst it was hot.

In the trust "your voice" staff engagement for July 2019 maternity staff fed negative comments such as staff not always being kept up to date and low manager visibility at times. However, they gave positive comments about the team spirit, working well together and about the changes in the unit.

Learning, continuous improvement and innovation

We saw evidence of quality improvement in all clinical areas. Some had been staff led such as the comm cell wall and others were as a result of feedback from women and their families

During our inspection we observed that one of the senior midwives had developed an "emergency response station". Instead of there being individual boxes or trolleys for each obstetric or neonatal emergency which is usual in many other maternity units, this one had two trolleys that had all of the equipment for each obstetric or neonatal emergency. Placed on the wall above were clipboards for each emergency. Staff just grabbed one trolley and the appropriate clipboard. There was good feedback from staff that had used it.

The unit did not have an alongside or freestanding midwifery led unit. At a time when some are being closed, this department is opening one of each.

Since the last inspection the trust was awarded UNICEF baby friendly gold standards. It was only the second trust in the North West to be awarded the standard.

Leigh Infirmary

Surgery

Facts and data about this service

Surgical services at Wrightington, Wigan and Leigh NHS Foundation trust are provided across three main hospital sites:

- **Royal Albert Edward Infirmary (RAEI)** for elective, emergency and day case surgery.
- **Leigh Infirmary** for day case surgery for clinically suitable patients.
- **Wrightington Hospital** for the majority of elective orthopaedic surgery.

Surgical patients are admitted for a wide range of procedures in the specialities of colorectal surgery, ENT, breast surgery, general surgery, gynaecology, ophthalmology, maxillo facial surgery, urology and vascular surgery.

The urology department offers a range of services for patients including rapid access clinics, prostate assessment, vasectomy, haematuria, one stop and out of hours evening clinics.

Trauma patients and those that may require post-operative HDU support following elective surgery are accommodated in the theatres on the acute Royal Albert Edward Infirmary site.

(Source: RPIR – Acute context tab)

The trust had 32,554 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 8,180, 17,595 were day case, and the remaining 6,720 were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Nursing staff received and kept up-to-date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified nursing staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-Fraud Awareness	432	455	94.9%	95%	No
Blood Collection	399	455	87.7%	95%	No
Blood Transfusion	388	455	85.3%	95%	No
Bowel Management Programme	435	455	95.6%	95%	Yes
Conflict Resolution	431	455	94.7%	95%	No
Delirium	179	455	39.3%	95%	No
Dementia Training	435	455	95.6%	95%	Yes
Emergency Planning	433	455	95.2%	95%	Yes
Equality and Diversity	431	455	94.7%	95%	No
Fire Safety	442	455	97.1%	95%	Yes
Health and Safety	431	455	94.7%	95%	No
Infection Prevention		455	0.0%	95%	No
Information Governance Clinical	435	455	95.6%	95%	Yes
Medical Devices	435	455	95.6%	95%	Yes
Medicine Safety	436	455	95.8%	95%	Yes
Moving and Handling Clinical	431	455	94.7%	95%	No
Resuscitation	436	455	95.8%	95%	Yes
Safe Use of Insulin	397	455	87.3%	95%	No
Slips Trips and Falls Clinical	430	455	94.5%	95%	No

In surgery at trust level, the 95% target was not met for any of the 21 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for medical staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-Fraud Awareness	115	159	72.3%	95%	No
Blood Collection	114	159	71.7%	95%	No
Blood Transfusion	114	159	71.7%	95%	No
Conflict Resolution	112	159	70.4%	95%	No
Delirium	114	159	71.7%	95%	No
Dementia Training	112	159	70.4%	95%	No
Emergency Planning	109	159	68.6%	95%	No
Equality and Diversity	112	159	70.4%	95%	No
Fire Safety	119	159	74.8%	95%	No
Health and Safety	105	159	66.0%	95%	No
Infection Prevention		159	0.0%	95%	No
Information Governance Clinical	115	159	72.3%	95%	No
Medical Devices	113	159	71.1%	95%	No
Medicine Safety	110	159	69.2%	95%	No
Moving and Handling Clinical	109	159	68.6%	95%	No
Resuscitation	118	159	74.2%	95%	No
Safe Use of Insulin	93	159	58.5%	95%	No
Slips Trips and Falls Clinical	110	159	69.2%	95%	No

Leigh Infirmary

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in surgery at Leigh Infirmary is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-fraud awareness	57	60	95.0%	95%	Yes
Blood collection	55	60	91.7%	95%	No
Blood transfusion	54	60	90.0%	95%	No
Bowel management programme	59	60	98.3%	95%	Yes
Conflict resolution	58	60	96.7%	95%	Yes
Delirium	30	60	50.0%	95%	No
Dementia training	58	60	96.7%	95%	Yes
Emergency planning	58	60	96.7%	95%	Yes
Equality and diversity	59	60	98.3%	95%	Yes
Fire safety	59	60	98.3%	95%	Yes
Health and safety	59	60	98.3%	95%	Yes

Infection prevention		60	0.0%	95%	No
Information governance clinical	59	60	98.3%	95%	Yes
Medical devices	59	60	98.3%	95%	Yes
Medicine safety	59	60	98.3%	95%	Yes
Moving and handling clinical	58	60	96.7%	95%	Yes
Resuscitation	58	60	96.7%	95%	Yes
Safe use of insulin	52	60	86.7%	95%	No
Slips trips and falls clinical	59	60	98.3%	95%	Yes

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff in surgery at Leigh Infirmary is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-fraud awareness	4	4	100.0%	95%	Yes
Blood collection	3	4	75.0%	95%	No
Blood transfusion	4	4	100.0%	95%	Yes
Conflict resolution	4	4	100.0%	95%	Yes
Delirium	4	4	100.0%	95%	Yes
Dementia training	4	4	100.0%	95%	Yes
Emergency planning	4	4	100.0%	95%	Yes
Equality and diversity	4	4	100.0%	95%	Yes
Fire safety	4	4	100.0%	95%	Yes
Health and safety	3	4	75.0%	95%	No
Infection prevention		4	0.0%	95%	Yes
Information governance clinical	4	4	100.0%	95%	Yes
Medical devices	3	4	75.0%	95%	No
Medicine safety	3	4	75.0%	95%	No
Moving and handling clinical	3	4	75.0%	95%	No
Resuscitation	4	4	100.0%	95%	Yes
Safe use of insulin	4	4	100.0%	95%	Yes
Slips trips and falls clinical	3	4	75.0%	95%	No

Records we reviewed at ward level confirmed however that all staff were up to date with mandatory training, with the only exceptions being for staff currently absent on leave.

The trust did not provide annual training on sepsis management as part of mandatory training. However, there were sepsis champions in the service to cascade learning and updates

Safeguarding

Staff understood how to protect adult patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Safeguarding training completion rates

The trust set a target of 95% for the completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Prevent	421	455	92.5%	95%	No
Safeguarding Vulnerable Adults	431	455	94.7%	95%	No
Safeguarding Children Level 2	245	254	96.5%	95%	Yes
Safeguarding Children Level 3	171	201	85.1%	95%	No

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Prevent	3	6	50.00%	95%	Yes
Safeguarding Vulnerable Adults	4	6	66.67%	95%	No
Safeguarding Children Level 3	1	2	50.00%	95%	No
Safeguarding Children Level 2	4	4	100.00%	95%	Yes

Leigh Infirmary

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in surgery at Leigh Infirmary is shown below:

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Vulnerable Adults	57	60	95.0%	95%	Yes
Prevent	57	60	95.0%	95%	Yes
Safeguarding Children Level 2	44	44	100.0%	95%	Yes
Safeguarding Children Level 3	11	16	68.8%	95%	No

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff in surgery at Leigh Infirmary is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Prevent	3	6	50.00%	95%	No
Safeguarding Vulnerable Adults	4	6	66.67%	95%	No
Safeguarding Children Level 3	1	2	50.00%	95%	No
Safeguarding Children Level 2	4	4	100.00%	95%	Yes

Staff had completed safeguarding vulnerable adults and safeguarding children level two training and local training records confirmed this was up to date. Staff were aware of the potential adult safeguarding issues which could arise in the service and described what actions they would take if they identified a safeguarding concern.

Staff could access the trust's safeguarding policy through the trust intranet and a safeguarding folder was available on the ward for staff to access further direction. The trust's adult safeguarding team were based at another hospital location in the trust, but were available by phone during ward opening hours. Staff said the safeguarding team were accessible and responsive in case of any queries. One member of staff told us of a safeguarding concern they had raised regarding a patient's relative, whose behaviour had changed due to a change in their medication. The safeguarding process was followed to provide appropriate support from the multi-disciplinary team for the patient and their relative.

The day case surgical ward provided care for under 18-year olds in some services. From October 2018 to September 2019 there were a total of twenty-four patients seen who were between 15-17 years old. Only the ward manager had completed safeguarding children level three training. We raised this query to the trust at the time of inspection. The trust provided a response indicating how they had applied nationally recognised guidance identified in 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019'. to the service.

Following the inspection the trust informed us that it had reviewed the requirements for safeguarding children level three training against the most up-to-date guidance for medical staff. The only member of medical staff that required level three safeguarding children training was the trust's lead paediatric anaesthetist and this member of staff was compliant.

At the time of the inspection clinical staff were not yet trained to level three adult safeguarding, as set out in the intercollegiate guidance Adult Safeguarding: Roles and Competencies for Health Care Staff. However, the trust was starting training in December 2019. The guidance expects that all staff will have achieved the appropriate competencies as set out in the guidance by 2021.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff followed infection control principles including the use of personal protective equipment (PPE). Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Handwashing facilities, hand gel and protective personal equipment, such as aprons and gloves, were available in the surgical ward, theatres and departments we visited. Wall-mounted hand gel dispensers were placed at ward entrances, with notices displayed to prompt visitors to clean their hands before entering the ward. Side wards were available if patients required isolation to manage infection risk during their admission. We saw "I am clean" stickers on different equipment in the ward and all equipment was visibly clean.

Housekeepers maintained cleaning schedules to ensure the environment was clean. Records we checked were up to date for equipment and environmental cleaning tasks.

On the Richmond urology unit, we saw there were effective systems in place for the management and decontamination of flexible endoscopes following investigations, including separate lifts used for transferring dirty and clean equipment.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment.

Resuscitation equipment in theatres, the day case surgery ward and the Richmond urology unit was stored securely on trolleys, accessible in an emergency. Staff completed daily and weekly checks of resuscitation equipment in clinical areas and we saw during inspection records of these checks were complete and up to date. Staff managed clinical waste well.

We observed some environmental defects in theatres. In one theatre there was an area of wall surface appearing to have been patched and not able to be appropriately cleaned; also an air temperature control unit appeared to not be functioning. We also observed the theatre door was pushed open by air flow and remained ajar. The anaesthetic room theatre door also remained slightly ajar and there was damaged fascia and exposed wood to the theatre exit door. We raised these concerns to the trust during inspection. Following the inspection, the trust confirmed the air temperature control was now managed by the trust's estates department and the control panel was no longer in use.

After the inspection, we also requested information about any incidents relating to the theatre environment and the trust provided details of five incidents occurring between June and October 2019. Included amongst these were: ventilation systems stopping just prior to patient transfer to anaesthetic room; theatre airflow system stopped working; and recurrent rising temperature in theatre one. In one case, further surgery was stopped until the fault rectified; another incident resulted in delay to the afternoon's list; the third incident resulted in the list being transferred to a different theatre. Another incident identified a fault in the fire alarm system and procedures during an evacuation. This was investigated by the trust's fire officer and action taken, including refresher training.

On the day case surgery ward at Leigh Infirmary, we observed the side rooms had coat hooks on the doors, presenting a possible ligature point risk. During the inspection, we raised this safety issue to the ward manager who took immediate action to have these removed. We were told side wards were used on occasion for patients with mental health illness and staff would document risk assessments where this was needed.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff completed risk assessments for each patient pre-operatively and at admission using a recognised tool, and reviewed this regularly, including after any incident. Staff identified and quickly acted upon patients at risk of deterioration.

The service followed the internationally recognised American Society of Anaesthesiologists' classification for pre-operative health, to assess suitability for patients to have day case surgery at Leigh Infirmary. Patients were required to meet a score according to this classification of not higher than one (the patient is completely fit and healthy), or two (the patient has mild systemic disease). Any patients with pre-existing co-morbidities or who required more complex surgery would be treated at the trust's other hospital locations.

Staff completed patient risk assessments at pre-assessment clinics prior to patients attending for surgery, including screening for Methicillin-resistant Staphylococcus aureus (MRSA) and treatment for this if identified as required.

On the day of surgery, nursing staff completed an updated risk assessment for patients. This identified any new changes in the patient's condition and noted any additional needs, such as dementia or learning disability. Nursing staff completed standardised risk assessments for patients' care plans, including falls risk assessment and risk of venous thromboembolism. The records we reviewed during inspection confirmed these had been completed and documented correctly.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. A daily safety huddle was held on the day case ward at the start of the morning shift to discuss any safety updates, review of incidents, staffing issues and debriefs from the previous day's caseload.

In theatres, a daily huddle took place at the end and not the start of the day; this had been agreed between staff as a less busy time and more useful to share debrief, feedback and information. Staff noted items for discussion in a communication book, although we saw there was no formal record of the discussions that were held.

The service used World Health Organisation (WHO) checklists to ensure the safety of operations. We saw all staff were attentive in the quiet times during these checks, and we observed communication was clear, following NHS England National Safety Standards for Invasive Procedures (NatSSIPs), and Local Safety Standards for Invasive Procedures (LocSSIPs).

Checks on emergency resuscitation trolleys in theatres had been completed in accordance with the trust's policy and equipment we checked was within manufacturers' recommended expiry dates. An emergency response station provided staff with guidance and equipment for different surgical emergency responses, including major haemorrhage, local anaesthetic toxicity; anaphylaxis and malignant hypothermia.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Nursing staff completed post-operative checks of patients on their return to the ward, following standardised National Early Warning Scores (NEWS) documentation. The trust identified an escalation policy based on patients' clinical assessment and NEWS scores. Staff told us that due to the nature of day case surgery and the medical fitness required for patients to undergo this, it was unusual for patients to require escalation, however procedures were followed if this need arose.

The trust's resuscitation team were not based at Leigh Infirmary, however, anaesthetic and medical staff at Leigh Infirmary would be available to respond in an emergency. All nursing staff on the ward were trained in intermediate life support skills and the ward manager had completed advanced life support skills training. Medical staff were not routinely available on site at Leigh Infirmary after 6.00pm. If staff were concerned about a patient's condition after 6.00pm, they would summon emergency ambulance services for urgent patient transfer to Royal Albert Edward Infirmary. Staff had no access to the critical care outreach team based at another hospital location in the trust, or means to escalate any concerns, but that they could contact the team for advice if required.

Patients being discharged from the surgery day case ward were provided with post-operative advice about mobilisation and 'stop the clot' information. Post-operative advice included, where relevant, contact details for out of hours community nursing services, or direction to attend hospital in case of any emergencies. Patients were booked a district nurse referral, or referral to the one stop clinic on their discharge.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. While we saw evidence the service ensured there were sufficient staffing there were frequent late staffing rota changes in theatre.

Trust level

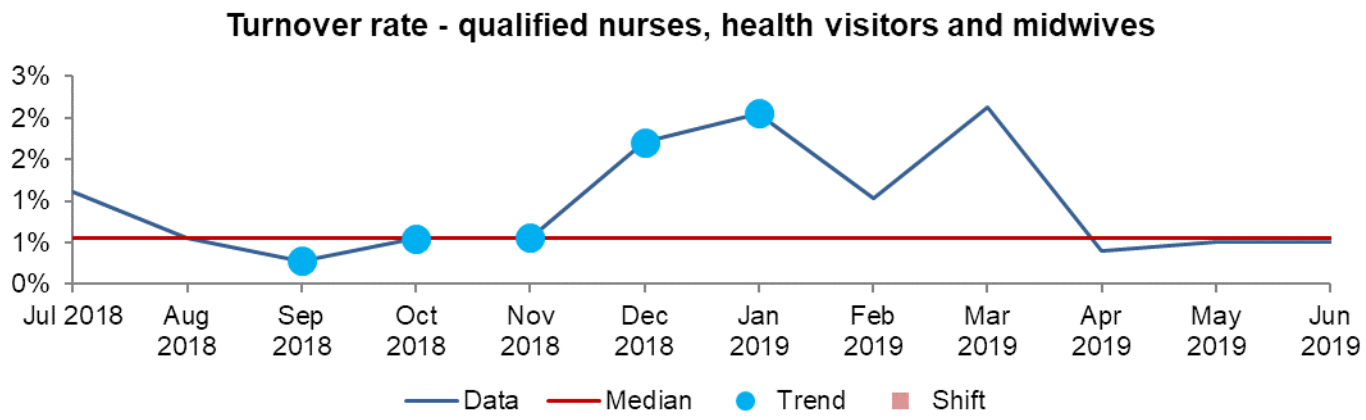
The table below shows a summary of the nursing staffing metrics in surgery at trust level compared to the trust's targets, where applicable:

	Surgery annual staffing metrics July 2018 – June 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		4%	9%	4.0%			
All staff	1,217.2	8%	12%	4.7%			
Qualified nurses	476.9	9%	11%	4.6%	20,455 (30%)	1,747 (3%)	22,201 (33%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

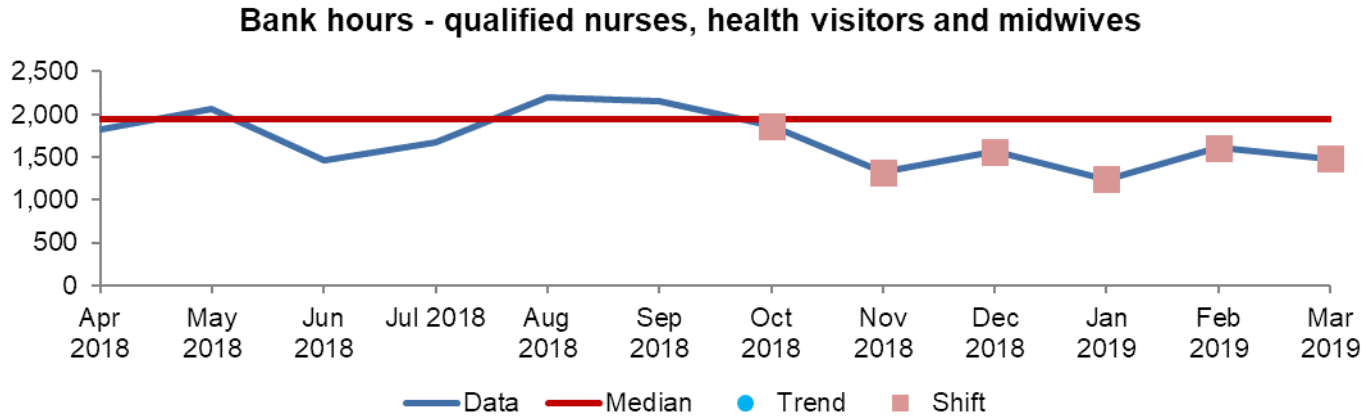
Nurse staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and sickness.

Turnover rates

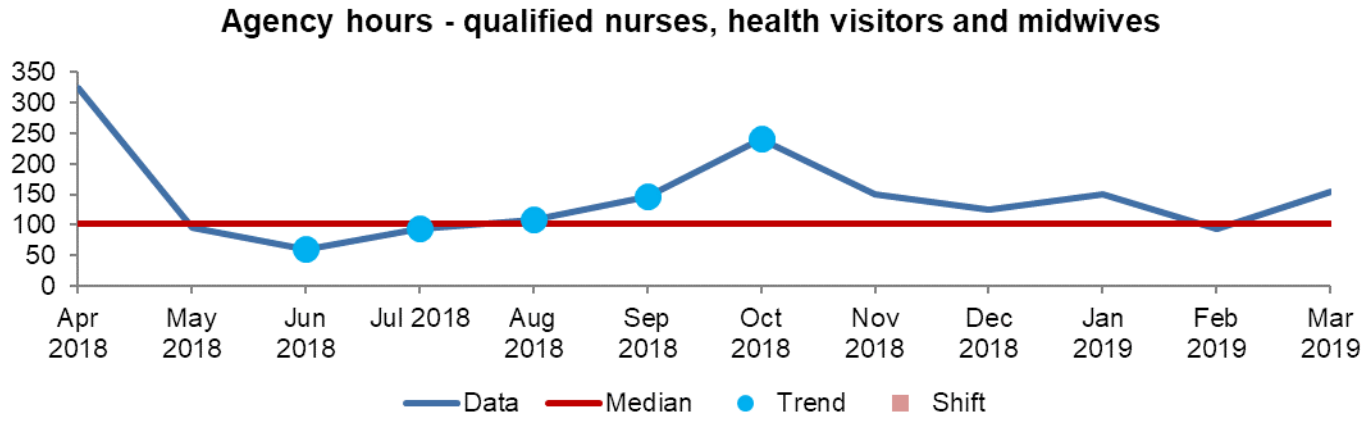


Monthly turnover rates over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from September 2018 to January 2019. Though this had improved to below 1% by April 2019.
Source: Routine Provider Information Request (RPIR) – Turnover tab)

Bank and agency staff usage



Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives shows a shift from October 2018 to March 2019.



Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from June 2018 to October 2018.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Leigh Infirmary

The table below shows a summary of the nursing staffing metrics in surgery at Leigh Infirmary compared to the trust's targets, where applicable:

	Surgery annual staffing metrics July 2018 – June 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		4%	9%	4.0%			
All staff	56.3	9%	11%	3.6%			
Qualified nurses	28.3	5%	4%	3.0%	268 (7%)	46 (1%)	314 (8%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within surgery at Leigh Infirmary were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness, bank and agency use.

The day case surgery ward at Leigh Infirmary had its own dedicated staffing establishment, identified from a staffing review in 2017 and was fully staffed at the time of our inspection. Staffing levels were sufficient to provide for the needs of patients accessing the service. The ward manager could adjust staffing levels daily according to the needs of patients. On occasions, staff could be moved to other wards in the trust to meet increased demands, however this was not a regular occurrence and most staff moves only occurred in response to winter pressures. The ward manager attended weekly planning meetings with the theatre manager, deputy performance manager and other service leads to schedule theatre sessions and plan staffing accordingly. Ward staffing rotas were planned three weeks in advance; where any changes were needed, staff worked together to cover these.

Theatre sessions would only be confirmed four weeks in advance of surgery, however, these could alter up to the week or day of surgery. Medical and theatre staff rostering was planned up to six weeks in advance, resulting in last minute changes and staffing shortages in theatres. The trust informed us that the roster was scrutinised and risk managed on a daily basis by the shift coordinator to give assurance that the appropriate skill mix was aligned to the clinical needs of the lists but also to reflect the requirements of the current status within the department. The trust said that this may require short notice roster amendments in response to events such as short term sickness or on the day cancellations. While we saw evidence the service ensured there were sufficient staffing there were frequent late staffing rota changes in theatre.

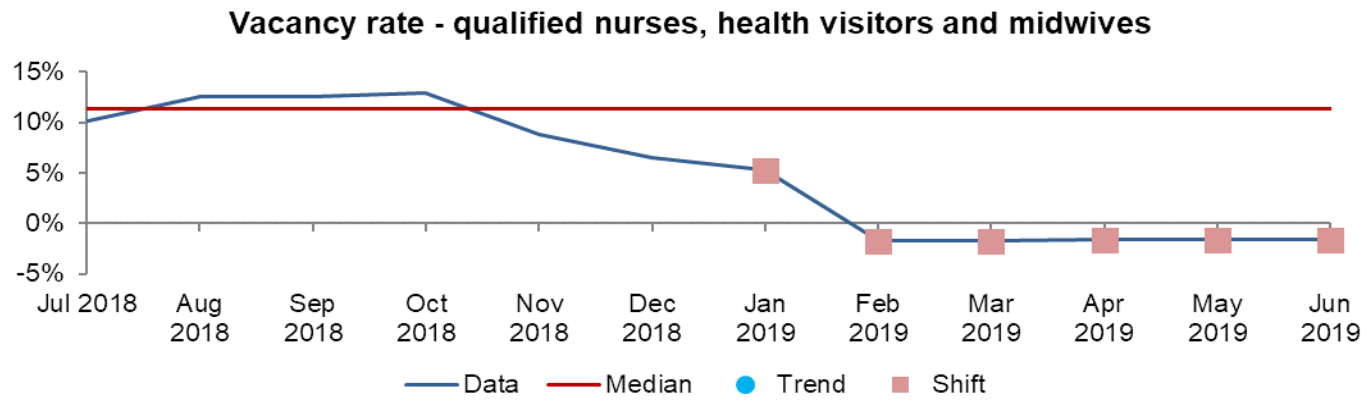
We were told that theatre staff worked flexibly to provide any cover needed where they could, however there was a reliance on bank and agency staff to fulfil gaps at the last minute. We also saw there was no 'lockdown' of theatre sessions, with an example of leave arrangements having been granted to a surgeon and arrangements for redeployment of their theatre session to another speciality. This session was unable to be taken up, meaning the theatre space was unused and staff rosters needed to be rearranged.

and use of agency staff to cover gaps.

We heard on average two to three theatre shifts per week needed cover from bank or agency staff. Data provided by the trust following inspection indicated that between April and September 2019, 43 theatres shifts were covered by bank and agency staff, with a further 22 shifts unable to be covered by bank and agency staff. The highest usage for qualified agency or bank staff was equivalent to 7% in this period, and for non-qualified agency or bank staff was equivalent to 6%. At the time of inspection, recruitment and interviews were taking place for two new theatre staff.

Additional funding for a part time registered nurse had been identified from work to reduce the rates of patients' cancellations and patients' 'did not attend' appointments. A theatre matron post had been identified, with a new member of staff due to start in this post the weeks following inspection.

Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from January 2019 to June 2019.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Medical staffing

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

Trust level

The table below shows a summary of the medical staffing metrics in surgery at trust level compared to the trust's targets, where applicable:

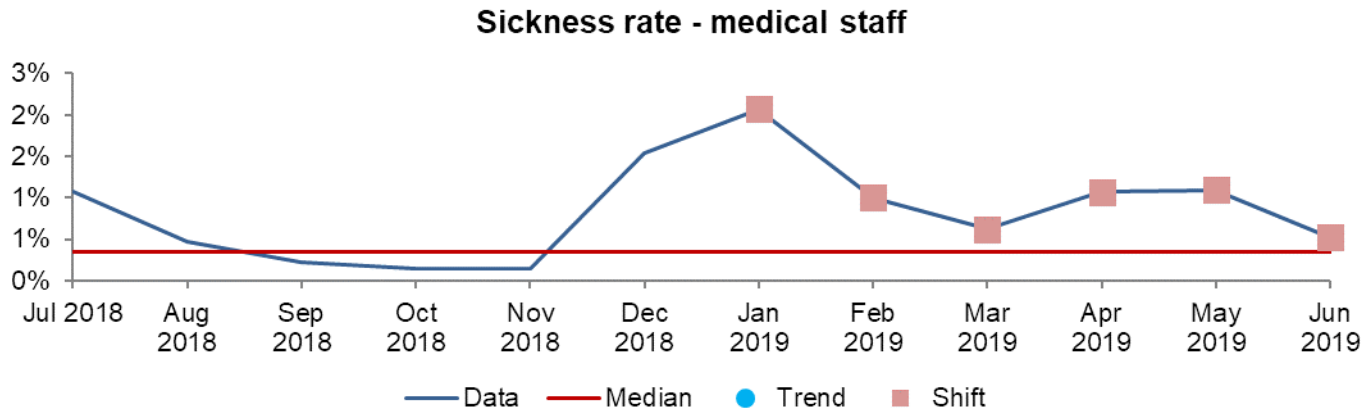
	Surgery annual staffing metrics July 2018 – June 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		4%	9%	4.0%			

All staff	1,217.2	8%	12%	4.7%			
Medical staff	240.1	12%	6%	0.8%	9,026 (2%)	9,234 (2%)	18 (<1%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and turnover.

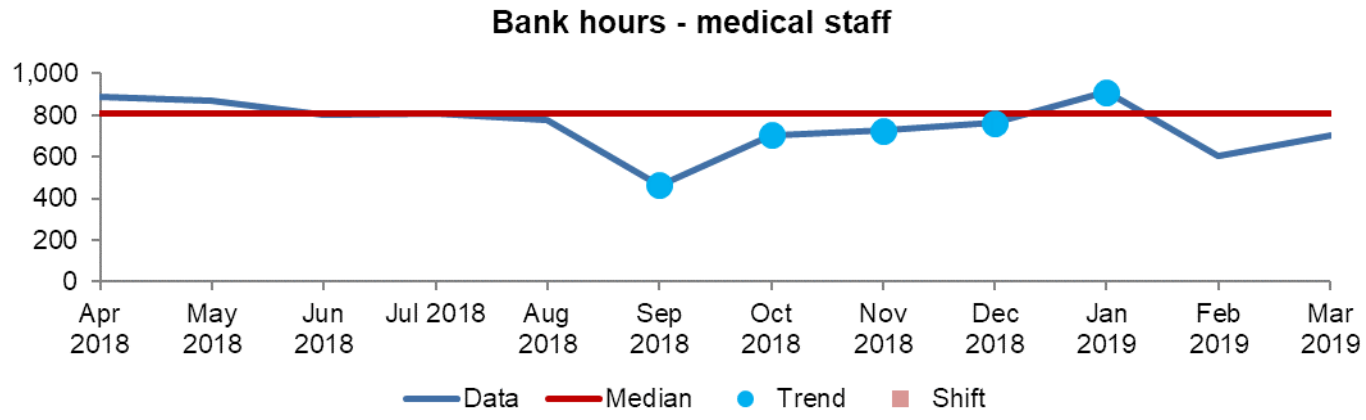
Sickness rates



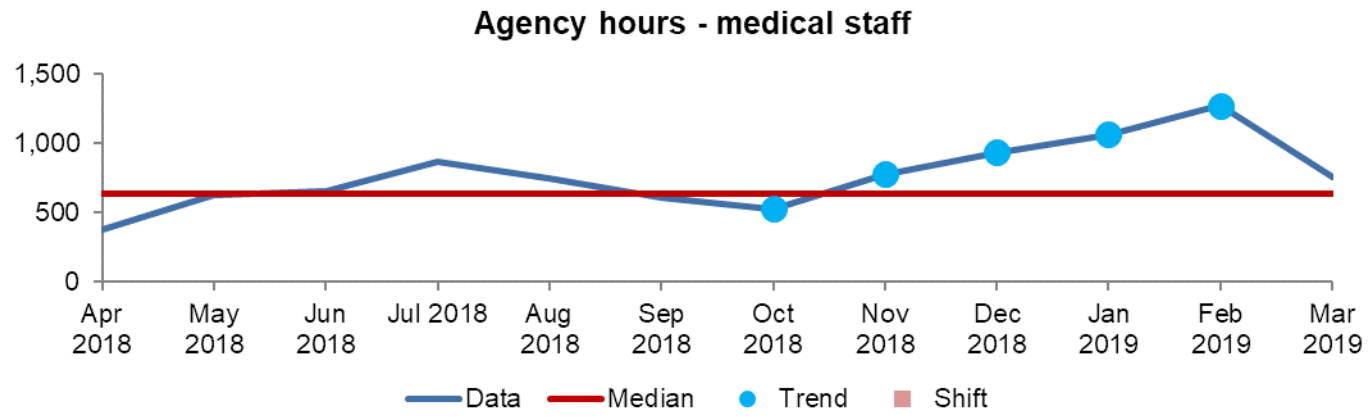
Monthly sickness rates over the last 12 months for medical staff shows a shift from January 2019 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage



Monthly bank hours over the last 12 months for medical staff shows an upward trend from September 2018 to January 2019.



Monthly agency hours over the last 12 months for medical staff shows an upward trend from October 2018 to February 2019.
(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

Leigh Infirmary

The table below shows a summary of the medical staffing metrics in surgery at Leigh Infirmary compared to the trust's targets, where applicable:

	Surgery annual staffing metrics June 2018 – July 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours**	**Annual locum hours**	**Annual unfilled hours**
Target		4%	9%	4.0%			
All staff	56.3	9%	11%	3.6%			
Medical staff	10.3	19%	0.0%	0.0%	0	22	0

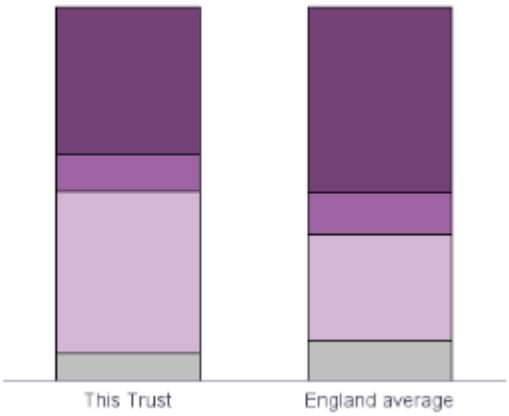
(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within surgery at Leigh Infirmary were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, bank use and agency use.

Staffing skill mix

In May 2019, the proportions of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust were lower than the England averages.

Staffing skill mix for the whole time equivalent staff working at Wrightington, Wigan and Leigh NHS Foundation Trust



	This Trust	England average
Consultant	39%	50%
Middle career^	10%	11%
Registrar Group~	43%	28%
Junior*	8%	11%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Medical staff attended the day case surgery ward on the day of surgery to obtain patient consent for procedures, or if they were conducting a procedure in the clinical treatment room. Consultants or senior medical staff would also review patients on the ward following their procedure and prior to discharge. There was no permanent medical presence on the ward apart from these activities. Where nurses had concern about any patient who needed a medical review, they would request this from surgical or anaesthetic staff who were on site at Leigh in theatres. Staff we spoke with said this was not a regular event but could happen on occasion, where patients needed a little more time for recovery before being discharged.

The Richmond urology unit had two permanent consultants, with a vacant third post which was being covered by a locum consultant. We heard there had been challenges with recruitment to this post, reflecting a national context in the urology speciality.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, we saw records were not always stored securely on the ward.

Staff used paper and electronic systems to record patient treatment and care. Patient notes were comprehensive, and all staff could access them easily. Nursing staff used electronic systems to document patient risk assessments and noted patient observations in their care plans. Pre-operative assessments were completed in electronic records. Care pathways were paper-based for some specialities, including for example for plastic surgery and ophthalmology. Records we checked during inspection were clear, complete and up to date.

We saw on the surgery day case ward that patient lists for the day's admissions were taped to the top of the nurses' station and a pile of case notes left unattended in the eye bay. There was a possibility that confidential patient details could be observed by other patients, relatives or members of the public. During the inspection we raised this concern to nursing staff for their further action.

Patient records were available to staff in a timely way and systems were in place for transfer of records to clinics and wards. When patients transferred to a new team, there were no delays in staff accessing their records. A taxi service was available for urgent transfer of patient notes for ward admissions, if this was needed.

Administrative staff told us there were issues with library storage of patient notes not in use. We saw four boxes of patient notes in the pre-operative clinic administrative office, which were unable to be stored in the trust's records library. The trust told us that it had undertaken a risk assessment and the risk had been escalated to the corporate risk register. One of the actions was to review library storage of patients notes not in use.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff followed current national practice to check patients had the correct medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Fridges used for storage of certain types of medicines were checked and fridge temperatures recorded correctly. We saw details of temperature and range of temperatures was documented. Records of temperatures for fridges used in theatres also recorded when theatres were closed.

On the day case surgery ward, controlled drugs were stored securely in a locked cabinet within a keypad secured room. Records of each dose administration were signed by two registered nurses.

Staff followed systems for recording and checking the administration and removal of ophthalmic insert medication, for patients having cataract surgery.

Incidents

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

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust reported four incidents which were classified as never events for surgery;

- August 2018: Wrong site surgery (Royal Albert Edward Infirmary): Incorrect teeth removed.

- September 2018 (Wrightington Hospital): Wrong site surgery: Anaesthetic injected to

incorrect hip.

- October 2018 (Royal Albert Edward Infirmary): Retained foreign object post procedure: Small piece of Durofibre left in situ following procedure

- December 2018 (Wrightington hospital): Wrong prosthesis: Wrong size prosthesis fitted during hip replacement.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from August 2018 to July 2019.

A breakdown of incidents by incident type is below:

- Five surgical/invasive procedures incident meeting SI criteria
- Three diagnostic incidents including delay meeting SI criteria (including failure to act on test results)
- Two sub-optimal care of the deteriorating patient meeting SI criteria
- One major incident/ emergency preparedness, resilience and response/ suspension of services
- One HCAI/Infection control incident meeting SI criteria
- One treatment delay meeting SI criteria
- One pressure ulcer meeting SI criteria
- One medication incident meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

Staff raised concerns and reported incidents and near misses in line with trust policy, using the trust's electronic incident reporting system. Staff received feedback following incident reporting and any wider learning from incidents was shared in the daily safety huddle. Also, a daily communication file was kept on the day case ward which contained a five-point communication sheet for staff to sign. During inspection we saw this included: prompts for staff to complete checks of lying and standing blood pressure for patients aged over 65 years old; an alert from the Medicines and Healthcare products Regulatory Agency (MHRA); and an internal patient safety notice regarding the use of examination lumiere lights, following a patient incident.

The division monitored performance in incident reporting and investigation. The surgery divisional governance report for September identified the number of outstanding investigation reports to be completed was reducing, with 171 investigations ongoing to complete; and the incident reporting rate had increased, with 217 incidents reported.

Staff received communications about investigations into serious incidents within the surgery division and were aware of the learning identified from other areas in the trust. Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Safety thermometer

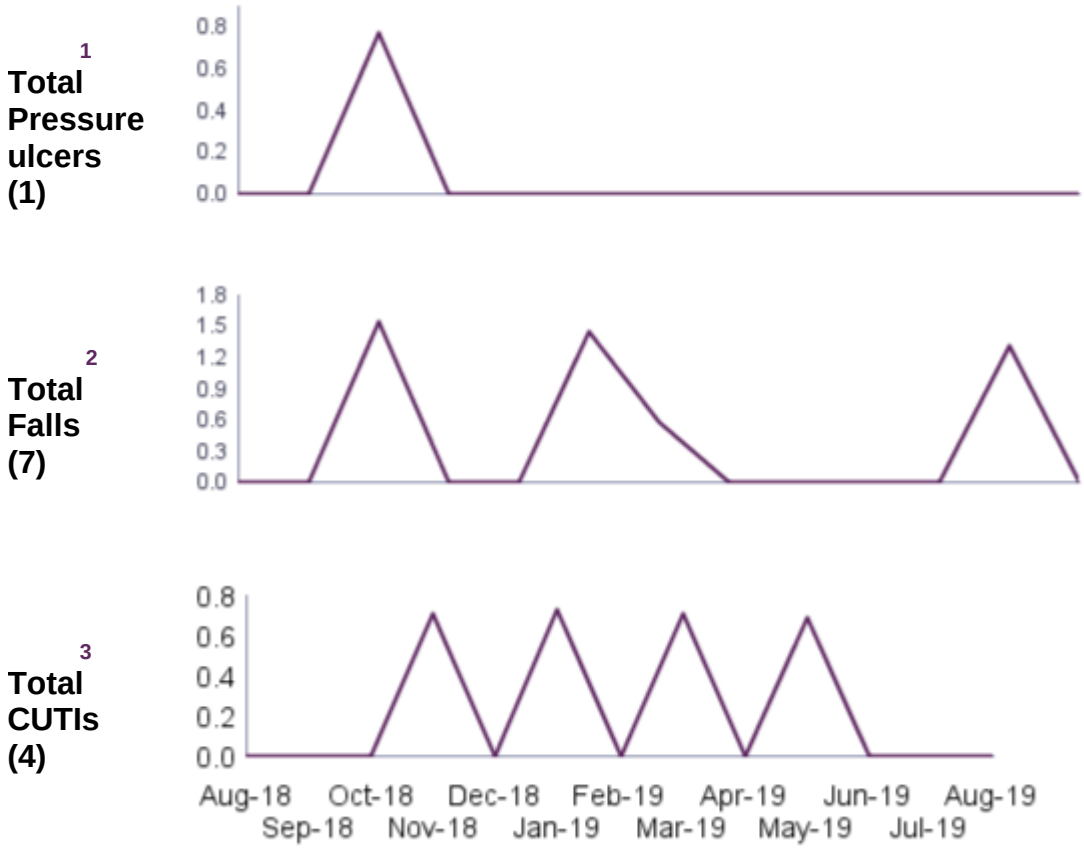
The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, seven falls with harm and four new catheter urinary tract infections from August 2018 to August 2019 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Wrightington, Wigan and Leigh NHS Foundation Trust



1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

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

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

Care and treatment was based on national guidelines including National Institute for Health and Care Excellence (NICE) guidelines. The service followed surgical pathways for different conditions, including for cataract surgery, breast surgery, and prostate surgery.

Guidelines, policies and standard operating procedures we saw were up to date and reviewed regularly to implement new guidance. However the surgery divisional governance report for September 2019 noted there were ten NICE guidelines awaiting nomination or completion. Staff shared information about any updates in daily handovers and ward meetings.

Policies and procedures were available on the trust intranet page for all staff, making them easily accessible. Policies appropriately referenced current good practice and national guidelines and documents contained clear guidance, referral flow charts, escalation pathways and other information.

The service participated in the trust's audit programme, with audits compared to recognised standards and guidelines both internally and nationally. Various local audits were completed in different services; these included an audit of cancellations for pain treatments, and audits of benign and malignant prostate conditions.

The ward completed a 'matrons mini audit' on a monthly basis to monitor outcomes in the service. Included in the audit for September 2019 were 'good compliance with hand hygiene' and 'safety huddle at the beginning of each shift working well'.

Senior nursing staff in theatres undertook audits on a quarterly basis to benchmark practice across the region.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Post-operatively, staff monitored patients' fluid intake and made sure they had eaten a meal prior to their being discharged.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately. Nurses assessed and recorded patients' pain scores and recorded these as part of NEWS documentation.

The service worked with pain consultants to treat patients with chronic pain. Clinic sessions were provided on the day case ward for administering ‘qutenza’ patches for relief of peripheral nerve pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

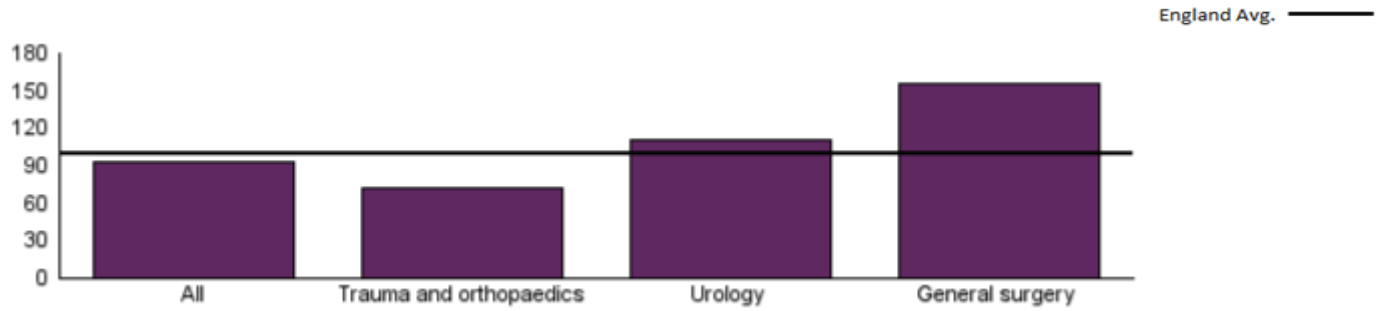
The service participated in relevant national clinical audits. Managers and staff used the results to improve patients' outcomes. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Relative risk of readmission

Trust level

From February 2018 to January 2019, all patients at the trust had a lower than expected risk of readmission for elective and non-elective admissions when compared to the England average.

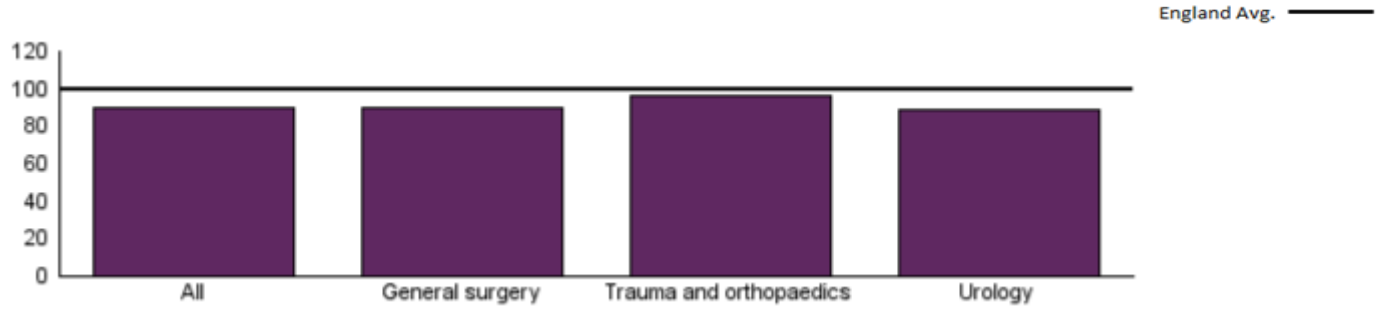
Elective Admissions – Trust Level



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in trauma and orthopaedics had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Patients in urology and general surgery had a higher than expected risk of readmission for elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level



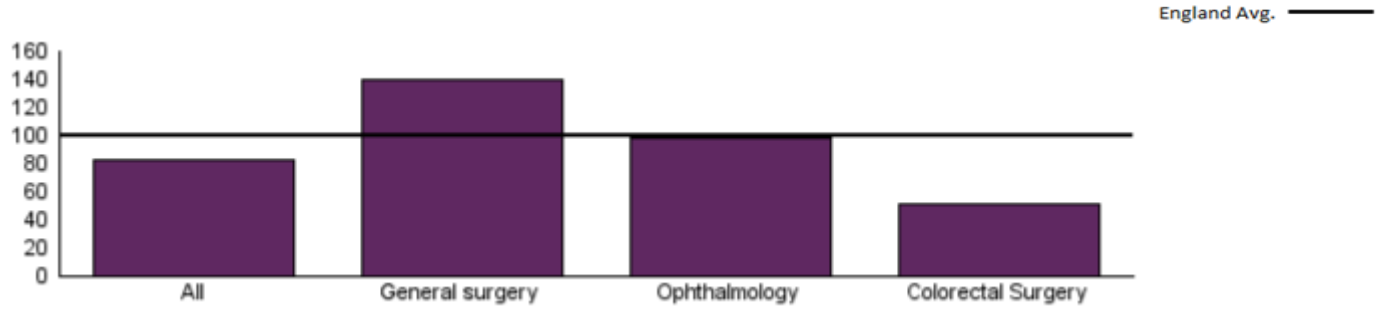
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in general surgery, trauma and orthopaedics and urology had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Leigh Infirmary

From February 2018 to January 2019, all patients at Leigh Infirmary had a lower than expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - Leigh Infirmary



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity

- Patients in colorectal surgery at Leigh Infirmary had a lower than expected risk of readmission for elective admission when compared to the England average.
- Patients in ophthalmology at Leigh Infirmary had a similar to expected risk of readmission for elective admissions when compared to the England average.
- Patients in general surgery at Leigh Infirmary had a higher than expected risk of readmission for elective admissions when compared to the England average.

(Source: Hospital Episode Statistics - HES - Readmissions (01/02/2018 - 31/01/2019))

Bowel Cancer Audit

The table below summarises the trust's performance in the 2018 National Bowel Cancer Audit.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other Trusts**	**Met national standard?**
Case ascertainment *(Proportion of eligible cases included in the audit)*	94.9%	Good	Good is over 80%
Risk-adjusted post-operative length of stay >5 days after major resection *(A prolonged length of stay can pose risks to patients)*	53.5%	Better than national aggregate	No current standard
Risk-adjusted 90-day post-operative mortality rate *(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure*)	2.2%	Within expected range	No current standard
Risk-adjusted 2-year post-operative mortality rate *(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient*	19.1%	Within expected range	No current standard

characteristics and provision of chemotherapy and radiotherapy)			
Risk-adjusted 30-day unplanned readmission rate *(A potential risk for early/inappropriate discharge is the need for unplanned readmission)*	8.0%	Within expected range	No current standard
Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection *(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)*	40.5%	Within expected range	No current standard

(Source: National Bowel Cancer Audit)

National Oesophago-gastric Cancer Audit

(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)

The table below summarises the trust's performance in the 2018 National Oesophago-gastric Cancer Audit.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other Trusts**	**Met national standard?**
Trust-level metrics *(Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)*			
Case ascertainment *(Proportion of eligible cases included in the audit)*	81.0-90%	Better	No current standard
Age and sex adjusted proportion of patients diagnosed after an emergency admission *(Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)*	6.1%	Better	No current standard
Risk adjusted 90-day post-operative mortality rate *(Proportion of patients who die within 90 days of their operation*)	Not eligible	Not eligible	No current standard
Cancer Alliance level metrics *(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.*			
Crude proportion of patients treated with curative intent in the Cancer Alliance *(Proportion of patients receiving treatment intended to cure their cancer)*	35.4%	Significantly lower than the national aggregate	No current standard

(Source: National Oesophago-Gastric Cancer Audit)

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The table below summarises the trust's performance in the 2018 National Ophthalmology Database Audit.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other Trusts**	**Met national standard?**
Trust-level metrics *(Measures of hospital performance in the treatment of cataracts*			
Case ascertainment *(Proportion of eligible cases included in the audit)*	98.4%	n/a	No current standard
Risk-adjusted posterior capsule rupture rate *(Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.*	0.8%	Within expected range	No current standard
Risk adjusted visual acuity loss *(The most important outcome following cataract surgery is the clarity of vision*)	0.5%	Within expected range	No current standard

(Source: National Ophthalmology Database Audit)

National Prostate Cancer Audit

The table below summarises the trust's performance in the 2018 National Prostate Cancer Audit.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other trusts**	**Met national standard?**
Men with complete information to determine disease status *(This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)*	97.0%	N/A	Did not meet
Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy *(A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)*	No data available	No data available	No current standard
Percentage of patients experiencing a	No data	No data	No current

severe urinary complication requiring intervention following radical prostatectomy *(Complications following surgery may reflect the quality of surgical care*)	available	available	standard
Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy *(External beam radiotherapy uses high-energy beams to destroy cancer cells)*	No data available	No data available	No current standard

(Source: National Prostate Cancer Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

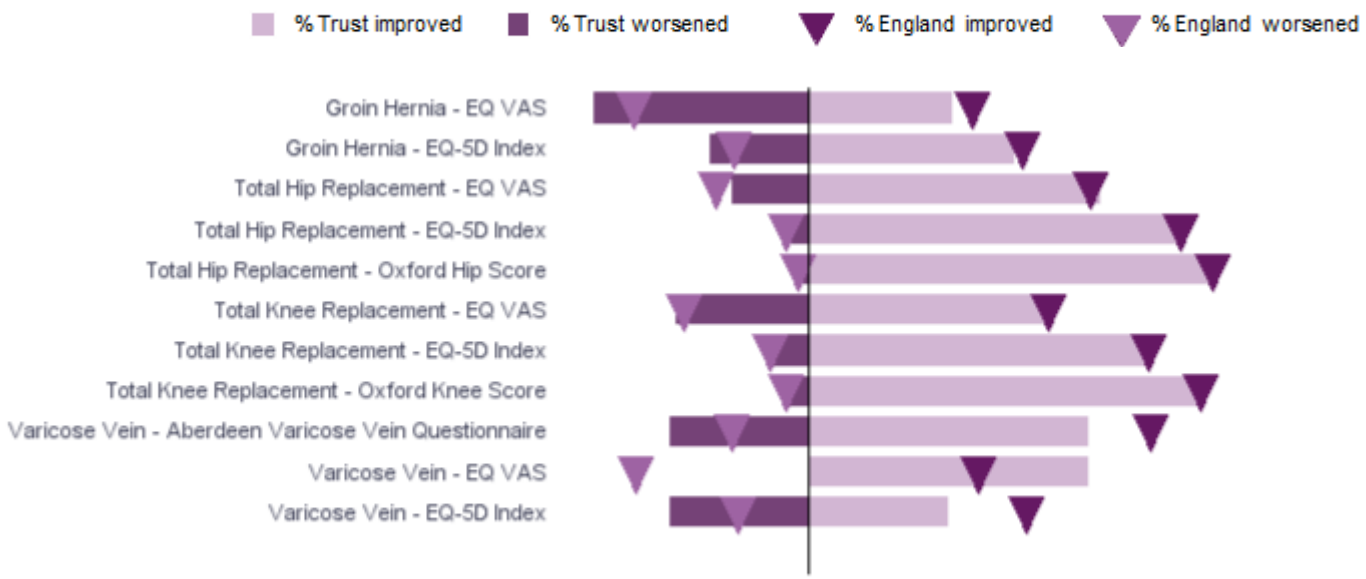
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

Visual analogue scale (EQ-VAS)

Visual analogue scale (EQ VAS) is, asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific Issues namely mobility self-care usual activities pain or discomfort anxiety or depression. The EQ-5D-5L uses 5 levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.



In 2016/17 performance on groin hernias was worse than the England average for EQ VAS and EQ-5D index.
For Varicose Veins, performance was worse than the England average for Aberdeen Varicose Vein Questionnaire and EQ-5D index, but for varicose vein EQ VAS trust performance was better than the England average.

For hip replacements, performance was about the same as the England average for all three measures.

For knee replacements was about the same as the England average for all three measures.

(Source: NHS Digital)

Competent staff

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

Appraisal rates

Trust level

From April 2018 to March 2019, 83.5% of required staff in surgery at trust level received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the tables below:

Staff group	Staff who received appraisal	Eligible staff	Completion rate	Trust Target	Met (Yes/No)
Administrative and clerical	96	109	88.1%	90%	No
Allied health professionals	56	66	84.8%	90%	No
Nursing and midwifery registered	308	365	84.4%	90%	No
Healthcare scientists	10	12	83.3%	90%	No
Additional clinical services	223	273	81.7%	90%	No

Add prof scientific and technic	33	44	75.0%	90%	No

Leigh Infirmary

From April 2018 to March 2019, 88.0% of required staff in surgery at Leigh Infirmary received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the tables below:

Staff group	Staff who received appraisal	Eligible staff	Completion rate	Trust Target	Met (Yes/No)
Administrative and clerical	4	4	100.0%	90%	Yes
Nursing and midwifery registered	28	32	87.5%	90%	No
Additional clinical services	12	14	85.7%	90%	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Staff had completed annual appraisals with their managers and identified development plans from this. Managers supported staff in their progress with regular review meetings. Managers made sure staff received any specialist training for their role.

Staff consistently told us they had opportunities for learning and development and the trust supported them in these; time was available for staff to focus on learning and development.

Coaching and mentoring schemes were promoted in the trust and staff had access to these. We spoke with a staff nurse who was completing a trust leadership development programme and planning to undertake an audit of ward attenders as part of this.

Nursing staff completed different competencies relevant to their area of practice, including some of the following skills: cannulation, antiseptic no touch technique (ANTT), and electrocardiogram (ECG) technique. The service had link nurses in different specialisms, including topics such as safeguarding; infection prevention and control; medicines safety; moving and handling; medical devices; and diabetes. Link nurses attended regular trust-wide meetings to develop their knowledge and skills to be able to support other staff locally. Link nurses shared subject updates and contact information for relevant services.

Staff in theatres completed medical devices competencies, although at the time we inspected, staff records of this were unclear. We were told that staff had completed relevant theatre competencies, however, these records were in the process of being updated to a trust-wide recording system for theatre staff.

An ophthalmology trained nurse was available on the surgery day case ward to support staff and patients with regards to cataract and eye surgery patients. The Richmond urology unit provided a range of nurse-led services for patients, including for prostate assessment, urodynamics testing and erectile dysfunction. Staff in this service also provided education and support for staff trust wide, including for nurse training in catheterisation technique. Specialist nurses participated in different regional networks, sharing best practice and clinical updates.

Bank or agency staff were provided with a local induction, including familiarisation with the theatre environment, documentation and procedures. However, the service did not keep extensive records to confirm local induction, or competencies for bank and agency staff and we saw only two completed available records at the time of inspection. We were told the service took their assurances that agency staff were suitably trained from the agency provider.

A practice education facilitator was available to support surgery staff, working across the trust's three hospital sites. We were told that in practice, visits were mainly to support Leigh Infirmary theatres when students were on placement rather than direct support for existing registered staff.

Medical staff we spoke with had completed a comprehensive induction to their role, including a meeting with the consultant prior to starting as well as a local and corporate induction.

Multidisciplinary working

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

Staff worked well together within the multidisciplinary team and care was co-ordinated to provide the right support for patients. There was good communication between staff, both within the service and externally; staff in all parts of the service engaged with both clinical and non-clinical staff in the course of their everyday activity. Staff worked across health care disciplines and with other agencies when required to care for patients.

There was effective liaison between hospital and community services, which had been enhanced through the establishment of a community matron role by the trust. This role had been recognised by both patients and staff for helping create a more patient-focussed approach. This role had also helped in co-ordinating appointments between GP and clinic services; patients we spoke with were highly appreciative about this.

Staff in the Richmond urology unit had worked closely with specialist urology services in a neighbouring NHS trust, as part of a regional development. There had been positive working arrangements to provide cover across areas, including for on call emergency response. Multidisciplinary team meetings were held weekly to review patients awaiting and receiving treatment on cancer pathways.

Seven-day services

Day case services were available five days a week to support timely patient care.

The surgery day case ward was open Monday to Thursday 7.00am to 8. 30pm. Pre-operative assessment clinics were available Monday to Fridays 8.15am-4.00pm. Operating theatre lists ran Monday to Thursday. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The Richmond urology unit was open Monday to Friday 8.00am to 5.00 pm. Patients were directed to attend the accident and emergency department outside these hours, where doctors in urology speciality provided an on-call service. The on-call urology service was operated between the trust and a neighbouring NHS trust.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards and units. Different leaflets were available providing information about specific individual conditions, such as prostate cancer, and cataract surgery. Notices displayed information about healthy nutrition and hydration for patients.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients attending for pre-operative assessment appointments at Leigh were provided with information about smoking cessation and healthy living, including referral to health trainers for patients who had a body mass index (BMI) of over 30. Depending on their

individual needs, patients could be referred or signposted to alcohol liaison or stop smoking services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Trust level

The trust set a target of 95% for the completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training modules from April 2018 to March 2019 at trust level for qualified nursing staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained /compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	424	455	93.2%	95%	No

A breakdown of compliance for MCA training from April 2018 to March 2019 at trust level for medical staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	95	163	58.3%	95%	No

Leigh Infirmary

A breakdown of compliance for MCA training modules from April 2018 to March 2019 for qualified nursing staff in surgery at Leigh Infirmary is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	58	60	96.7%	95%	Yes

A breakdown of compliance for MCA training from April 2018 to March 2019 for medical staff in surgery at Leigh Infirmary is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	1	2	50.0%	95%	No

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients

who lacked capacity to make their own decisions Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff followed the trust's consent policy and documentation for patients undergoing day case surgery.

We saw staff had completed Mental Capacity Act training and were aware of the needs of patients who may lack capacity, following the trust's consent procedures. Patients with additional and complex needs were not routinely seen in the service, however staff described how they worked with other agencies to support patients with needs in relation to their mental capacity. We heard of how a multi-agency meeting and best interests' decision meeting was arranged for a patient with learning disability who was attending for dental surgery.

Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness.

Nurses introduced themselves and communicated well to ensure patients' understanding.

There was a caring culture fully embedded across the service. Throughout our inspection we saw staff were focussed on providing patient-centred care, and this was confirmed in positive patient feedback. We observed how nursing staff followed up concerns about patients' appropriate follow up care at home. Nurses actively followed up contact with community services to ensure appropriate support was provided for patients where needed after their appointment.

Staff spent time with patients to ensure care was not rushed; care was delivered with kindness, compassion and understanding, which extended to include patients' relatives and carers.

The trust offered chaperones for patients who wished to have this; we saw signs displayed to promote the service.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff were aware of the anxieties patients may have when attending for their surgical procedures and were calm and clear when communicating with patients, providing information and reassurance.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff were sensitive to the emotional needs of patients undergoing investigations, and who received difficult news about their diagnosis. They took time to support patients when they were upset.

Patients we spoke with commented that staff appeared to have a positive mental attitude and that this helped them in their experience of hospital care.

Understanding and involvement of patients and those close to them

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

Staff supported patients to make informed decisions about their care. Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff spoke to patients and their families sensitively and appropriately, dependent upon individual need. Patients' family members were encouraged to be involved to support patients during their appointments and admission for surgery.

Patients and their families told us that they received relevant information in a manner which they understood. We spoke with one patient attending treatment at a clinic appointment who said the

nurse had come to see them and explained what would happen next. The nurse also provided literature about their procedure and made time to answer their questions.

Is the service responsive?

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. Facilities and premises were appropriate for the services being delivered.

Surgery services from Leigh Infirmary provided three theatres for adult surgical patients. One theatre was dedicated to ophthalmology surgery, with a separate recovery area. Patients were admitted to and discharged from the surgery day case ward on the day of their procedure. In addition a 'one stop' clinic was provided in the Richmond urology unit, including provision of a number of day case investigations and procedures. The day case unit provided ophthalmology and general surgery services for patients.

Priority was made for residents of Leigh and Wigan to access appointments for pre-operative assessment at Leigh Infirmary, providing patients with a more local service, where possible.

Since the last inspection an additional clinical room had been created on the surgery day case ward to offer a pain clinic service.

Specialist nurses in urology and ophthalmology provided outreach and support for outpatient clinics at the trust's other locations.

On the day case ward at Leigh, we observed several patients who appeared unsure of where to go, until they were noticed by a member of staff. The main ward entrance door was open, but the nurses' station was not visible from here, so patients could be left wandering; in addition, there was no clear signage to direct patients from the ward entrance.

The trust worked on collaboration with a local council initiative to provide support for patients over the age of 50 living in Wigan living alone who were being discharged. The service could make referrals to 'Wigan and Leigh Pensioners Link' for patients to receive a free transport service and a welcome home bag of basic food items.

Meeting people's individual needs

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

Wards were designed to meet the needs of patients living with dementia and patients living with dementia were supported according to their individual needs. A forget-me not flower symbol on patient notes and magnet on the patient's bed board would prompt staff to be aware of their additional needs. We saw during inspection how one patient with a cognitive impairment was provided with a side room, responding to their cognitive impairments and following discussion with their relative. Staff providing care were sensitive and kind throughout this communication. The trust also used a poppy symbol for veterans, if patients wished to have this.

Patients with a learning disability would be identified during their pre-operative assessment, and this information flagged to the ward. Wherever possible, patients with a learning disability would be offered a side room on the ward during admission, to allow relatives and carers to be close to them.

A Macmillan support worker had recently been recruited to enhance urology services in providing care for patients with different types of urological cancers. A counselling room was available in the Richmond urology unit; nurses would use this for patients undergoing chemotherapy treatment, or if patients were distressed on hearing difficult news about their diagnosis.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Written information displayed was in English language formats although staff could arrange for alternative language translations where this was needed. The service had access to the trust's interpreter and translation services for patients whose first language was not English. We saw in the pre-operative assessment clinic that notices were displayed advising a hearing loop was provided. However, staff told us the hearing loop was broken and had been out of action for several weeks. Following the inspection the trust told us this had not been logged with the estate's helpdesk, but following the inspection had been logged.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

The trust's ophthalmology department had developed an information leaflet for patients having cataract surgery. This provided information about the condition and procedure, explaining the advantages of different types of treatment as well as advice for post-operative care and discharge.

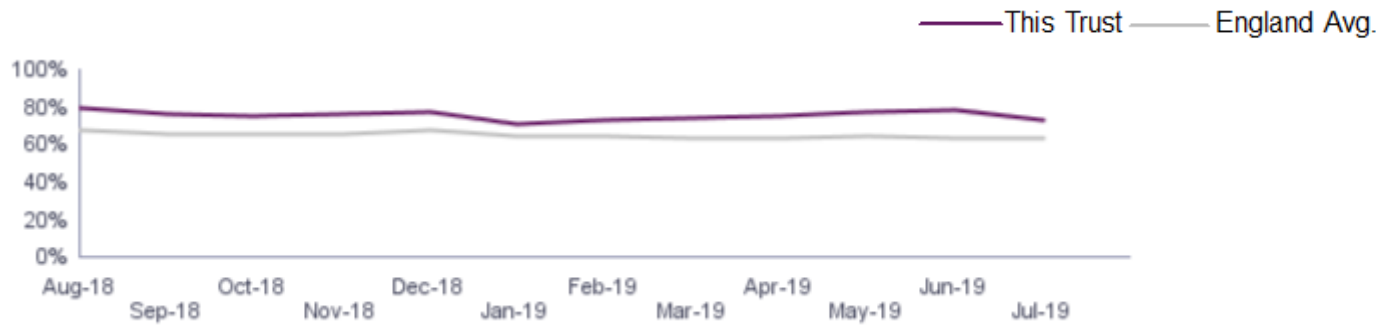
Specialist nurses in urology were planning an introductory evening for mindfulness sessions, to help patients receiving treatment for different bladder conditions.

Access and flow

Referral to treatment (percentage within 18 weeks) - admitted performance

From August 2018 to July 2019 the trust's referral to treatment time (RTT) for admitted pathways for surgery was consistently higher than the England average.

Trust performance ranged from 70.6% to 79.0% compared to the England average, which ranged from 63.3% to 68.3%.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Four specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Plastic surgery	93.9%	78.9%
Trauma & orthopaedics	84.0%	58.4%
Ear, nose & throat (ENT)	72.1%	60.0%
Oral surgery	59.1%	55.2%

Three specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Urology	64.3%	74.9%
Ophthalmology	49.9%	62.2%
General surgery	49.2%	72.1%

People could mostly access the service when they needed it and received the right care promptly. However, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards for urology, ophthalmology and general surgery.

Length of waiting list times varied depending on the surgical speciality; we were told in some cases a patient could receive an appointment for their procedure within two weeks of their pre-admission assessment appointment. However, there were longer waiting times within different specialities. We were informed during inspection that in ophthalmology waiting lists had risen following a consultant's retirement. Additional capacity clinics covered by a locum consultant had reduced this waiting time to six weeks.

We spoke with divisional leaders who referenced several factors which they had identified in contributing to a 15% increased referral rate during 2018. One of the key issues was perceived to be the repatriation of patients to the trust's services, and the impact of external system-wide reconfigurations.

At the time of inspection, the trust identified 22 cases at Leigh Infirmary that had breached the 18-week waiting list time for laparoscopic cholecystectomies. Following inspection, the trust explained that all patients listed for surgery at Leigh would be informed by the consultant that should they experience an acute episode of symptoms they should present to hospital. If this occurred the consultant would review the patient's position on the waiting list and would re-prioritise as required. Arrangements were also in place to meet additional capacity, through provision in the private sector, with some patients booked to accessing these services during November and December 2019.

The urology service based at the Richmond urology unit was a busy clinic environment, offering same day appointments for some urgent patients, as well as routine booked assessment and review appointments for other patients. One patient we spoke with had been offered a same day treatment due to their being a gap in clinic appointments. During inspection we also saw patients who had been in the waiting area for some time. Patients said staff were clear about informing them of any delays in appointment times and we saw notices displaying updates of waiting times.

Cancelled operations

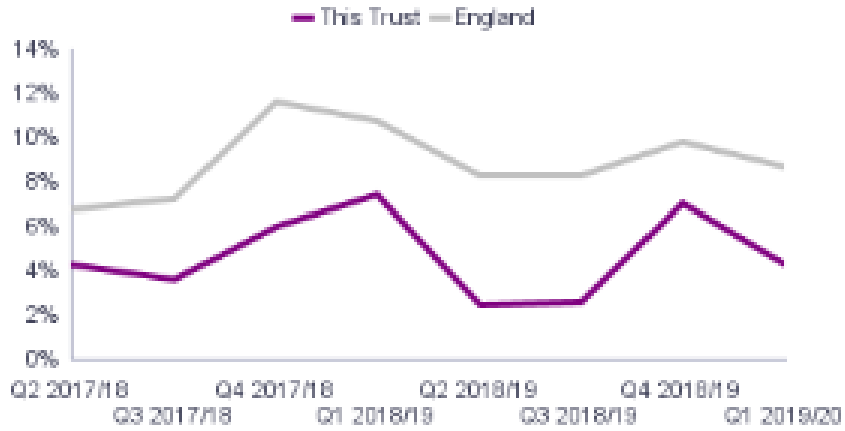
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

Over the two years, the percentage of patients with cancelled operations and not treated within 28 days has been consistently lower than the England average. Trust performance has ranged between 2% and 7% across the period.

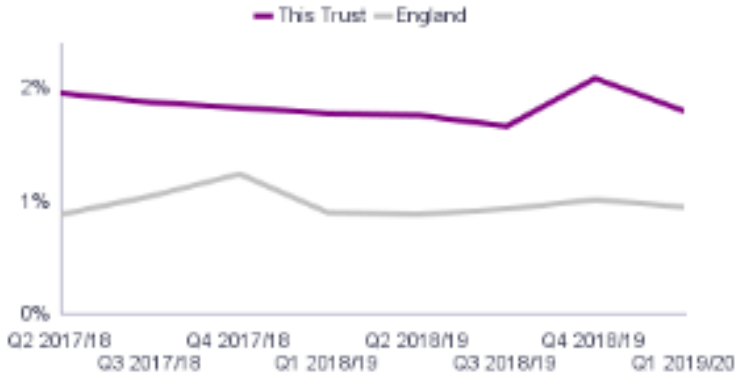
In the latest quarter, Q1 2019/20 the trust cancelled 208 surgeries, and of those cancellations 4%

of patients weren't treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Wrightington, Wigan and Leigh NHS Foundation Trust



Cancelled Operations as a percentage of elective admissions - Wrightington, Wigan and Leigh NHS Foundation Trust



Over the two years, the percentage of cancelled operations as a percentage of elective admissions at the trust has been consistently higher than the England average.

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

The surgery day case ward had introduced initiatives to reduce the levels of cancellations. The service recognised there had been issues where patients had attended for admission and either their condition or medication had changed since the time of their original booking, with the result their surgery could not proceed. This meant surgery would have to be cancelled on the day itself. An audit of cancellations for the pain service provided data for 53 cancelled patient appointments, between April and September 2019. Of these, nine patients cancelled due to being unfit with acute illness; eight patients were unfit for surgery; eight patients were unsuitable; five patients did not attend; and in two cases the treatment was not necessary.

In order to address this issue of late cancellations, and to help reduce the numbers of patients who did not attend their appointments, the service had introduced a phone checklist system, whereby patients were contacted one week prior to their admission date. Any new changes

would be confirmed during this call and appointments cancelled or rearranged, allowing time for rescheduling the slot. Early results indicated the system had helped to reduce the numbers of late cancellations.

Clinic areas also provided a text message reminder service to prompt patients about their appointment date and time.

Patient moving wards per admission

The day case surgery ward at Leigh Infirmary arranged for patients to be transferred to an acute inpatient ward at Wigan Infirmary, in the event they required overnight admission to aid their recovery.

Learning from complaints and concerns

Summary of complaints

Trust level

From July 2018 to June 2019 the trust received 118 complaints in relation to surgery (22.6% of total complaints received by the trust).

The trust's complaints and concerns standing operating procedure sets out the different timescales for responding to complaints depending on the complexity of the complaint and issues raised. The agreed response times are 30 days, 40 days, 60 days or 90 days. The trust took an average of 52.1 working days to investigate and close complaints.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	49	41.5%
Patient care	20	16.9%
Communications	13	11.0%
Admissions & discharges (excl delayed discharge due to absence of a care package)	13	11.0%
Appointments	8	6.8%
Waiting times	5	4.2%
Values and behaviours (staff)	3	2.5%
Prescribing	2	1.7%
Pdw	1	0.8%
Trust admin policies procedures incl patient record management	1	0.8%
Facilities	1	0.8%
Access to treatment or drugs	1	0.8%
No subject given	1	0.8%
Total	**118**	**100.0%**

Leigh Infirmary

From July 2018 to June 2019 the trust received eight complaints in relation to surgery at Leigh Infirmary (6.8% of total surgery complaints received by the trust).

The trust took an average of 54.8 working days to investigate and close complaints, this is not in line with their complaints policy of 30 working days to complete complaints.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Admissions & discharges (excl delayed discharge due to absence of a care package)	2	25.0%
Clinical treatment	2	25.0%
Appointments	2	25.0%
Communications	2	25.0%
Total	**8**	**100.0%**

The trust also received eight complaints in relation to ophthalmology services at Boston House.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

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

During inspection we reviewed complaints relating to Leigh surgery services and saw appropriate acknowledgement of the issues raised and an apology to the patient.

The division's monthly quality report identified seven red graded complaints had been received during September and the divisional complaint closure rate was 30% in month.

We saw notices displayed in clinic areas for patients to inform reception if they had been waiting more than 15 minutes. However, in the areas we visited, whilst we saw some posters, we did not see leaflets or other information clearly displayed which offered advice to patients of how to raise a complaint or concern.

'Senior nurse walkabouts' had been introduced on surgical wards in follow up to learning identified from a complaint. This ensured that a senior member of ward staff would be visible during visiting hours, checking with patients in each bay to see if there are any concerns or queries. Initial feedback has shown that this has had a positive impact.

Number of compliments made to the trust

From July 2018 to June 2019 there were 416 compliments received for surgery at the trust (13.3% of all received trust wide).

Data provided by the trust did not identify the numbers of compliments, or the type, by ward and area, for surgery services offered at Leigh. We observed during inspection cards and messages of thanks were displayed the day case ward. Some positive comments included 'Staff were friendly, professional and ultra- courteous in every way' and 'every person we came into contact with was warm, friendly and extremely accommodating.'

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service, they understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. However, senior leaders in the division were not always visible and approachable in the service for patients and staff.

Staff we spoke with were positive about their immediate managers' and the trust's leadership, although we heard differing views about the visibility of leaders within the service and the trust executive. Staff were generally aware of the structures within their services, however, only a few staff said there had been an executive walk around the Leigh surgery services. There was a sense from some staff of Leigh services feeling somewhat isolated within the surgery division.

We spoke with divisional leaders of the service who had an understanding of the issues the service faced as a whole. Leaders recognised and were particularly aware of the regional system-wide issues that had a bearing on service development. This had some impact on leaders' ability to make decisions for directing local progress in the meantime.

Medical staff we spoke with said they had particularly selected their job based on the development opportunities offered, as well as recommendations from another colleague who had worked at the trust previously.

Vision and strategy

The service did not have a clear vision and strategy for surgical services, which were dependent on progress in regional developments within the wider health economy. However, leaders and staff understood the trust's vision and strategy and knew how to apply this in monitoring progress.

The surgical division's leaders identified a strategic document, which broadly outlined different options for the future delivery of services at Leigh Infirmary. These plans considered various possibilities, including for services to remain unchanged; as well as for focus on particular surgical specialities, associated with proposed refurbishment and/ or building development. We heard however there was no developed detail of implementation at this stage, with any decisions and progress being determined by external influences. Leaders in the division of surgery were aware of external influences, such as the commissioning of surgical services across the Greater Manchester Health and Social Care Partnership and the uncertainty around changes, creating challenges to planning.

The trust promoted a vision and a set of values which were used in communications to the public and members of staff across the trust. The trust's vision was to make a positive difference to people's lives. Staff we spoke with could readily identify the trust values of safe, effective and caring said these were meaningful and relevant to the work of the service. Staff's appraisal discussions were focussed on the trust's values and themes. We saw during inspection that staff routinely demonstrated behaviours which were in accordance with the trust values.

Culture

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

The culture in the service was extremely positive and many staff described working in surgery services at Leigh Infirmary as being 'like part of a family'. Many of the staff we spoke with had been with the trust for longer than five years, with several having been employed there throughout their career. Staff were passionate about their services and demonstrated a strong patient-centred focus in their work.

We observed staff were open and supportive in their communications; staff attitudes and morale appeared positive in all the areas we visited. With only isolated exceptions, staff said they felt valued for their work and recognised by the trust for their services. Staff had a clear sense of their 'Leigh identity' within the trust; although we heard this sometimes created a feeling of isolation and 'being out on a limb', nevertheless this didn't conflict with a genuine pride in the service and the trust as a whole.

Staff were sensitive to the needs of their colleagues and worked professionally to help each other where needed. Staff were appreciative of their local managers and the matron of the service, for the support and direction they provided. We saw all staff were consistently respectful to patients and their relatives, demonstrating the trust's values in their behaviour.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was an established trust committee structure for monitoring clinical quality and patient safety, with monthly governance meetings of the divisional quality executive committee attended by divisional service leaders. Service performance and audit outcomes were monitored on a regular basis, with improvement actions identified and progress measured.

Divisional leaders held a weekly huddle to review and discuss any issues regarding the safety and quality of the service. Communications were shared from this review to wards and departments, via a senior nurse group, with senior nurse 'walk arounds' and quality champions in different clinical areas to support this. The division's leaders were proud of the work achieved through engagement with the trust's quality champions initiative.

Each division created a monthly governance report which was shared with staff. The reports were split into five domains safe, effective, caring, responsive and well led. We saw that they covered incidents, risk, audit results, safety alerts, mortality and morbidity, NICE guidance and complaints. The reports were shared with staff monthly by email.

Each surgical speciality had a 'clinical cabinet' meeting, attended by key staff in different areas of performance, including ward managers, governance and business managers. These staff reviewed key service information including serious incidents, mortality, complaints and waiting lists. The division had processes to escalate any areas of concern to the trust's executive leaders.

There was a weekly senior nurse communication cell which was attended by the senior nursing staff for all wards and theatres. The structure of the meeting was that each speciality provided an update about incidents, complaints and risks, this was also an opportunity for the senior leadership team to share information from higher meetings to take back to the staff on the ground. [DJ1]

The theatre's quality and governance lead for surgery was available, shared with the service based at Wigan; with a day and a half was allocated to surgery services at Leigh.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. However, they did not always identify and escalate relevant risks and issues, or identify actions to manage risks and reduce their impact. Risk registers did not identify key environmental issues in theatres which we observed during inspection.

The service had a risk register which identified key risks and progress of actions to mitigate these. Divisional leaders and managers had good awareness of service risks and could provide current updates of the actions to reduce these. However, during the inspection we saw some environmental concerns in theatres which had not been identified for action and we raised these to the trust.

Risk registers were reviewed at monthly quality and safety meetings, with escalation of any risks to the corporate risk register where this was indicated. Senior staff including governance leads, consultants, matrons and ward managers attended these meetings, to review relevant issues, regarding the risk register, safety incidents and performance.

The local risk register in Leigh theatres identified the top three risks as: the nurse call buzzer being inaudible throughout the unit; one of the two theatre lifts intermittently malfunctioning; and turnaround time for decontamination of instruments. Staff said the decontamination service was from an external provider in service level agreement; and the issues were a continuing source of delay which impacted on scheduling; however, we saw there were appropriate actions being followed up by the trust for this.

The service had a business continuity plan and policies for management of major incidents.

Information management

The service collected reliable data and analysed it. Managers could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Senior staff had access to the information they needed to monitor performance and to ensure there was sustained or improved standards of care. The electronic system provided a performance dashboard which was split into five domains safe, effective, caring, responsive and well led. Senior nurses on each ward had access to the performance dashboard for their ward.

Clinical staff had access to patients' investigation results and there were no concerns regarding any delays in receiving these.

Important information such as safety alerts, minutes of meetings and key messages were shared in safety huddles and displayed on notice boards in staff areas to help keep staff up to date and aware of issues. Staff could access relevant information, such as policies and other guidance, via the trust's intranet.

The service used different IT systems for certain activities and there were no concerns regarding the availability of these systems.

Engagement

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

The trust's brochure 'Your stay with us' was provided to each patient on their admission. This outlined the trust's services and details of what patients could expect during their admission.

The division's monthly quality report identified increased performance in patient engagement survey results during September 2019, with 11 out of 12 green scores and one red score. Ten of the questions had increased in their percentage scores compared to August's results.

Specialist nurses in urology services supported a bi-monthly meeting for patients with urological cancer conditions.

The trust engaged with volunteers, who we saw were managing the hospital's main entrance reception desk during the inspection. Patient volunteers were also conducting in a Patient Led Assessment of the Care Environment (PLACE) review of the services at Leigh Infirmary.

The trust promoted a 'talksafe' initiative, an open forum on the trust intranet for staff to share ideas and experiences of new and different ways of working. One member of staff we spoke with had a role as a talksafe champion, supporting staff engagement activities. The trust had a Freedom to Speak Up Guardian and staff were aware of their role; during our inspection the trust was promoting Freedom to Speak Out month.

Learning, continuous improvement and innovation

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

The surgery day case ward were the first ward in the trust to achieve the trust's bronze 'Aspire' award and the ward manager had achieved the trust's recognising excellence award in 2018 for leadership.

On the day case surgery ward we saw a 'myQ' for staff to suggest ideas and improvements to the service. This had been recently introduced and we saw one idea suggesting how to try and increase the size of the treatment room on the ward.

The surgery day case ward had won a trust competition for design of the trust's intranet logo 'Wally'.

During 2019 the trust invited staff from all areas to participate in a 'dragons' den' contest, to submit ideas for delivering improvements in patient care, staff experience and/or financial benefits. Of the 20 shortlisted applications, 10 came from the surgical division, and all were successful in their application for funding. This included funding for Holmium laser equipment, to provide day case treatment for patients with prostate cancer in the Richmond urology unit. This treatment limited the need for admission and more invasive surgery. Staff told us the unit was the first in the country to provide this.

The urology service was the first place in Greater Manchester to perform two Holmium Laser Enucleation of the Prostate (HoLEP) surgery, an endoscopic procedure using high powered laser energy.

The urology service had also won the trust's recognising excellence award for the urological cancer patient support group.

Staff received recognition for 'going the extra mile'; theatre staff had been nominated for a trust 'Innovation and Teamwork' award for implementation of additional ophthalmic lists and discharge of patients from theatre recovery to home.

Wrightington Hospital

Surgery

Facts and data about this service

Surgical services at Wrightington, Wigan and Leigh NHS Foundation trust are provided across three main hospital sites:

- **Royal Albert Edward Infirmary (RAEI)** for elective, emergency and day case surgery.
- **Leigh Infirmary** for day case surgery for clinically suitable patients.
- **Wrightington Hospital** for the majority of elective orthopaedic surgery.

Surgical patients are admitted for a wide range of procedures in the specialities of colorectal surgery, ENT, breast surgery, general surgery, gynaecology, ophthalmology, maxillo facial surgery, urology and vascular surgery.

The urology department offers a range of services for patients including rapid access clinics, prostate assessment, vasectomy, haematuria, one stop and out of hours evening clinics.

Trauma patients and those that may require post-operative higher dependency unit support following elective surgery are accommodated in the theatres on the acute RAEI site.

(Source: RPIR – Acute context tab)

The trust had 32,554 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 8,180, 17,595 were day case, and the remaining 6,720 were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Nursing staff received and kept up-to-date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training.

Managers monitored mandatory training and alerted staff when they needed to update their training. We were told the admin team sent a monthly report for training compliance. Staff were given study time to complete training but this was cancelled on occasion due to staffing pressures on the ward.

Mandatory training completion rates

The trust set a target of 95% for the completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified nursing staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-Fraud Awareness	432	455	94.9%	95%	No
Blood Collection	399	455	87.7%	95%	No
Blood Transfusion	388	455	85.3%	95%	No
Bowel Management Programme	435	455	95.6%	95%	Yes
Conflict Resolution	431	455	94.7%	95%	No
Delirium	179	455	39.3%	95%	No
Dementia Training	435	455	95.6%	95%	Yes
Emergency Planning	433	455	95.2%	95%	Yes
Equality and Diversity	431	455	94.7%	95%	No
Fire Safety	442	455	97.1%	95%	Yes
Health and Safety	431	455	94.7%	95%	No
Infection Prevention		455	0.0%	95%	No
Information Governance Clinical	435	455	95.6%	95%	Yes
Medical Devices	435	455	95.6%	95%	Yes
Medicine Safety	436	455	95.8%	95%	Yes
Moving and Handling Clinical	431	455	94.7%	95%	No
Resuscitation	436	455	95.8%	95%	Yes

Safe Use of Insulin	397	455	87.3%	95%	No
Slips Trips and Falls Clinical	430	455	94.5%	95%	No

In surgery at trust level, the 95% target was not met for any of the 21 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for medical staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Anti-Fraud Awareness	115	159	72.3%	95%	No
Blood Collection	114	159	71.7%	95%	No
Blood Transfusion	114	159	71.7%	95%	No
Conflict Resolution	112	159	70.4%	95%	No
Delirium	114	159	71.7%	95%	No
Dementia Training	112	159	70.4%	95%	No
Emergency Planning	109	159	68.6%	95%	No
Equality and Diversity	112	159	70.4%	95%	No
Fire Safety	119	159	74.8%	95%	No
Health and Safety	105	159	66.0%	95%	No
Infection Prevention		159	0.0%	95%	No
Information Governance Clinical	115	159	72.3%	95%	No
Medical Devices	113	159	71.1%	95%	No
Medicine Safety	110	159	69.2%	95%	No
Moving and Handling Clinical	109	159	68.6%	95%	No
Resuscitation	118	159	74.2%	95%	No
Safe Use of Insulin	93	159	58.5%	95%	No
Slips Trips and Falls Clinical	110	159	69.2%	95%	No

Data was not available aggregated to Wrightington Hospital.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Post inspection we requested assurance that staff treating young people (16-17 year olds) at Wrightington Hospital had the appropriate level of child safeguarding training. The trust had seen 79 patients aged between 16 and 17 in the last 12 months. There were safeguarding level three trained staff within the division for staff to refer to for support and guidance if needed.

At the time of the inspection clinical staff were not yet trained to level three adult safeguarding, as set out in the intercollegiate guidance Adult Safeguarding: Roles and Competencies for Health Care Staff. However, the trust was starting training in December 2019. The guidance expects that all staff will have achieved the appropriate competencies as set out in the guidance by 2021.

Staff knew how to make a safeguarding referral and who to inform if they had a concern. Staff we spoke to had not made a safeguarding referral, but were knowledgeable about what to do if they had a concern.

Safeguarding training completion rates

The trust set a target of 95% for the completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Prevent	421	455	92.5%	95%	No
Safeguarding Vulnerable Adults	431	455	94.7%	95%	No
Safeguarding Children Level 2	245	254	96.5%	95%	Yes
Safeguarding Children Level 3	171	201	85.1%	95%	No

The tables below include Prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Prevent	3	6	50.00%	95%	Yes
Safeguarding Vulnerable Adults	4	6	66.67%	95%	No
Safeguarding Children Level 3	1	2	50.00%	95%	No
Safeguarding Children Level 2	4	4	100.00%	95%	Yes

Following the inspection the trust informed us that it had reviewed the requirements for safeguarding children level three training against the most up-to-date guidance for medical staff. The only member of medical staff that required level three safeguarding children training was the trust's lead paediatric anaesthetist and this member of staff was compliant.

Data was not available for Wrightington Hospital.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection.

The ward areas we visited had suitable furnishings which were clean and well-maintained. We saw patients rooms were clean and spacious. Patients we spoke to told us they were happy with the cleanliness of their rooms and staff infection control measures.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff working in ward and theatre areas were bare below the elbow and had appropriate PPE and adhering to trust infection control principles. Hand washing facilities and hand gel stations were available in ward and theatre areas.

Staff worked effectively to prevent, identify and treat surgical site infections in accordance with The National Institute for Health and Care Excellence (NICE) CG74.

Public Health England encourages trusts to report surgical site infection data against 17 categories. Four of these (all orthopaedic) are mandatory and there is a requirement to conduct surveillance for at least one orthopaedic category for one period in the financial year. The remaining 13 categories can be reported against on a voluntary basis. The trust provided evidence that they had submitted surveillance data for every hip and knee joint replacement. They submitted quarterly data to Public Health England on a rolling 12 month data collection programme. Clinician diagnosed surgical site infections were confirmed using a root cause analysis. The findings were entered into a database, which could be audited.

The trust reported April 2018 to March 2019 a surgical site infection rate in joint replacement surgery as an average of 0.5%. The results broken down showed there were 14 joint replacement surgical site infections out of 2869 procedures. The rates for the previous 12 months were 0.6% for joint replacements and 0.9% for trauma. The results demonstrated that the trust had remained within the acceptable limits for infection rates in all the reported areas in accordance with Public Health England's regulations. The service monitored the themes and trends identified as part of the root cause analysis process. It had been identified that there were no re-occurring concerns which required them to take action to improve.

The trust had an off-site facility which was contracted to decontaminate and sterilise equipment. Staff told us on occasion there had been a delay in returning equipment, but theatre lists had been managed to reduce the number of cancelled operations.

Patients were routinely screened for methicillin-resistant staphylococcus aureus (MRSA) and methicillin-susceptible staphylococcus aureus (MSSA) pre-operatively. The hospital was part of a unique national collaborative for Quality Improvement for Surgical Teams (QIST) for MSSA. MSSA is a common cause of infection in joint replacement surgery. The initiative included screening patients for MSSA and the use of a body wash and nasal gel treatments for patients carrying the bug.

Environment and equipment

The design, use and maintenance of facilities, premises and equipment did not always reduce the risks to patients to keep them safe. The older theatre area was in poor condition and was affected by leaks and flooding at times of heavy rainfall. There were outstanding repairs at the time of our inspection such as the main theatre access door magnetic lock and theatre two door was broken.

Access to wards and preoperative assessment clinic was via a buzzer system. Access to theatres was via swipe access. However, the main theatre access doors magnetic locks were not working during our inspection. This posed a risk that unauthorised access could be gained by members of the public and entry was not secure.

The theatre areas were spread over three areas, the older main theatre area, upper limb theatre area and the newer barn theatre area.

The theatre fabrication within the main theatre area (theatre two, three, four and nine) were in poor condition. We saw evidence of the deterioration and damage caused by excessive rain water, the state of the facilities and repair jobs still outstanding. Theatre four anaesthetic room vacuum shut off value glass was broken with a label attached stating the job number from 25 April 2019. Theatre two scrub sink had exposed pipes and water from the sink emptied into an open gully into the drain. We saw equipment had been moved to prevent damage from leaking roofs and the reception area was no longer in use.

Staff told us that after heavy rainfall the roof leaked in different areas and at times surface water also flowed through one of the theatre corridors. As a consequence there were occasions when a back-up theatre had to be used to avoid the use of the corridor. The service had moved rooms around to reduce the impact of leaks from the roof.

In theatre two the door to the theatre was broken during the inspection and was ajar approximately four inches. Staff told us the door was damaged so it could not close and was stuck in an open position. This was reported 17 October 2019 and again 22 October 2019. During our inspection the door had swung open during an operation when a staff member tried to shut the door. This was escalated to senior management and the theatre was closed for the door repair to be completed.

Staff disposed of clinical waste safely. The service had appropriate arrangements for managing waste and clinical specimens to keep people safe on the wards and in theatre. However, the waste collection system in main theatre was not appropriate. The collection of waste from the main theatres was only accessible by foot. Waste had to be manually taken out of the bins and carried through a small winding pathway to. This had not been identified as a risk on the theatre risk assessment.

The upper limb and barn theatre area fabrication were in good condition. The barn theatre was a purpose built open plan space with four operating pod areas. Staff told us they were pleased with the working environment as it had enabled support from other colleagues during complex surgeries.

The service had suitable surgical equipment to help them care for patients.

Implants were recorded in a database, in line with national guidance.

Each department we visited had sufficient access to resuscitation trolleys which were kept in accessible areas. In addition, the theatres department had a separate paediatric resuscitation trolley. The trust had a system where all trolleys were standardised so that staff knew where to find what they needed in the event of an emergency situation. Completion of the daily trolley checks were audited by the trust's resuscitation team on a monthly basis.

We reviewed two resuscitation trolleys across the service. In the main we found that daily checks had been completed as per the trust's policy and we sampled equipment and sundries and found that in the main the required equipment was present and within manufactures expiry dates.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff completed risk assessments for each patient pre-operatively and at admission using a recognised tool, and reviewed this regularly, including after any incident. Staff identified and quickly acted upon patients at risk of deterioration.

The pre-operative assessment service followed NICE NG45 routine preoperative tests for elective surgery guidance. We saw examples where patients with complex needs such as dementia and learning disabilities were identified, appropriate care plans and risk assessments were completed. The care plans included which location the surgery would take place depending on the post-operative care required. Patients were referred to Royal Albert Edward Infirmary if a level two high dependency service was required as this was not provided at Wrightington Hospital.

The service followed national guidance for national patient safety agency (NPSA): 5 steps to safer surgery, NICE QS3 all patients on admission, receive an assessment of venous thromboembolism (VTE) and bleeding risk. On the day of admission nursing staff completed updated risk assessments for patients. This identified any new changes in the patient's condition and noted any additional needs that may not have been identified at the pre-operative assessment clinic. We reviewed two patients records post-operative and found the risk assessments had been completed and documented on the electronic computer system.

The service used World Health Organisation (WHO) checklists to ensure the safety of operations. We saw all staff were attentive in the quiet times during these checks, and we observed communication was clear, following NHS England National Safety Standards for Invasive Procedures (NatSSIPs), and Local Safety Standards for Invasive Procedures (LocSSIPs).

Checks on emergency resuscitation trolleys in theatres had been completed in accordance with the trust's policy and equipment we checked was within manufacturers' recommended expiry dates. An emergency response station provided staff with guidance and equipment for different surgical emergency responses, including major haemorrhage, local anaesthetic toxicity; anaphylaxis and malignant hypothermia.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The wards used the national early warning score (NEWS2) to monitor signs of deterioration. Staff we spoke to were knowledgeable about monitoring patients for signs of deterioration and escalating concerns for medical review.

In theatre the service followed local safety standards for invasive procedures (LocSSIPs) based on the National Safety Standards for Invasive Procedures (NatSSIPs). During surgery patients were continually monitored with cardiac telemetry. Systems and processes were in place for emergency support, blood components for transfusion and the transfer of patients to another hospital. The number of patients transferred within the trust from Wrightington to Royal Albert Edward Infirmary for the period January 2018 to December 2018 was 71 and two patients were transferred to another trust.

Staff shared key information to keep patients safe when handing over their care to others. The service had introduced different initiatives in ward and theatre areas to help share information. On ward one a trial had started one week prior to our inspection for a paper form handover prompt. The barn theatre had started to have continuity of anaesthetic and recovery staff for the patient. The service wanted to reduce handover time, help patient experience and identify any deterioration sooner. We were told that this was achieved for approximately 50% of patients as staff were undergoing additional training to work in both anaesthetic and recovery areas of theatre.

Patients were given advice and information about post-operative care including contact details for out of hours community nursing services or direction to attend their local hospital in case of any emergencies. Patients were

Nurse staffing

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

Staffing levels for each shift was displayed on staffing boards in each ward for planned and actual. During our inspection we observed staffing figures were met in the main. On the occasion where staffing did not meet with the expected numbers, cover was provided with additional support staff or ward manager.

Senior nursing staff on the wards had access to a 'safe care application' which was accessed through an electronic device. The application worked out staffing according to care hours which is a nationally recognised standard. The senior nursing staff inputted into the application the staff rostered that day and the acuity of the patients, the application then worked out the care hours required for each shift and indicated if the staffing was adequate to meet the patients' needs. We were told senior nursing staff updated the application three times per day and they were able to make requests for additional staff based on this. Staff were positive about the application and felt it made obtaining more staff an easier process. The application also allowed the senior staff to see what the staffing picture was across other wards and identify where support could be accessed internally prior to requesting external staff.

There was an approved bank and agency provider where senior nursing staff could access staff. We were told that there was no senior approval required to request staffing if unfilled shifts had been identified. There were local inductions in place for bank and agency staff which covered orientation and the review of relevant policies and procedures

Theatre and ward rotas were produced between four and six weeks in advance. We were told staffing levels had improved over the last twelve months and the use of agency staff was limited due to staff covering as bank staff.

Trust level

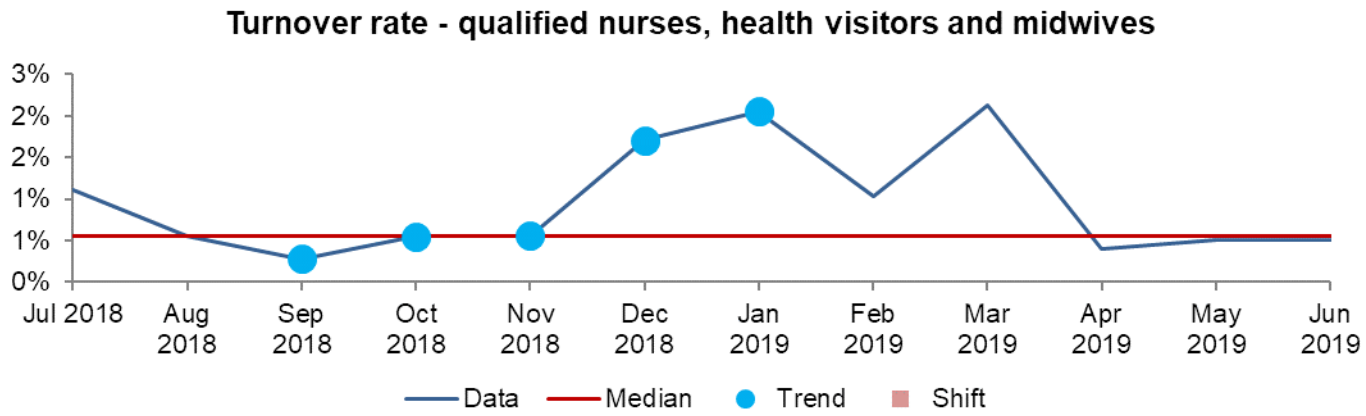
The table below shows a summary of the nursing staffing metrics in surgery at trust level compared to the trust's targets, where applicable:

	Surgery annual staffing metrics						
	July 2018 – June 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		4%	9%	4.0%			
All staff	1,217.2	8%	12%	4.7%			
Qualified nurses	476.9	9%	11%	4.6%	20,455 (30%)	1,747 (3%)	22,201 (33%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and sickness.

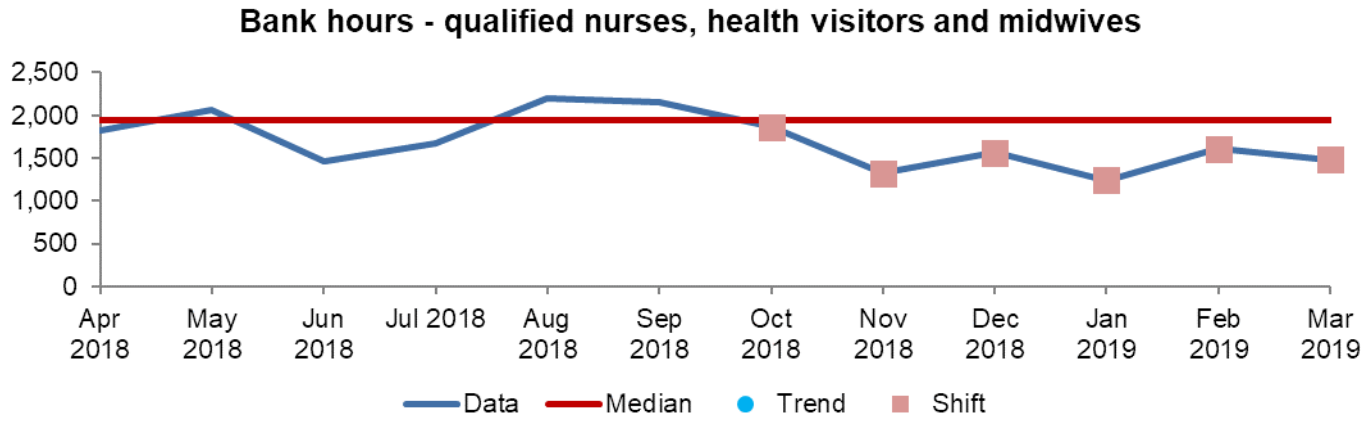
Turnover rates



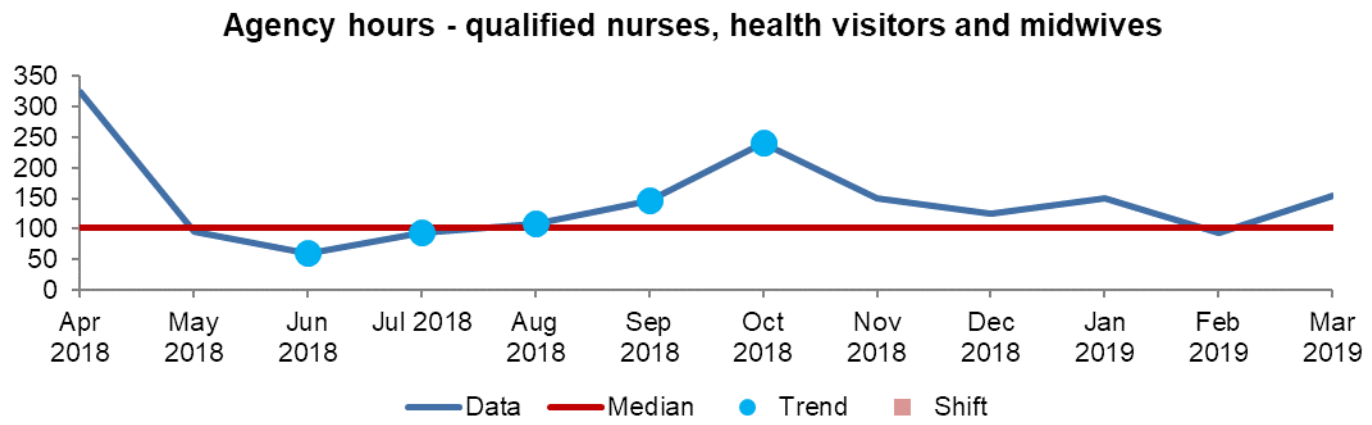
Monthly turnover rates over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from September 2018 to January 2019. Though this had improved to below 1% by April 2019.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Bank and agency staff usage



Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives shows a shift from October 2018 to March 2019.



Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from June 2018 to October 2018.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Wrightington Hospital

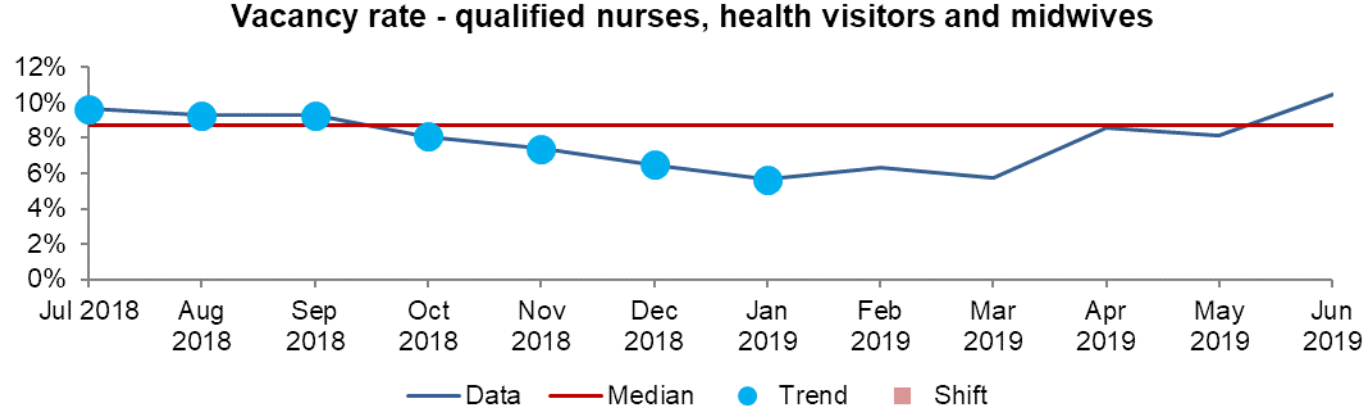
The table below shows a summary of the nursing staffing metrics in surgery at Wrightington Hospital compared to the trust's targets, where applicable:

	Surgery annual staffing metrics July 2018 – June 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		4%	9%	4.0%			
All staff	602.2	6%	11%	5.4%			
Qualified nurses	260.1	8%	7%	6.3%	11,709 (38%)	919 (3%)	12,628 (41%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within surgery at Wrightington Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and agency use.

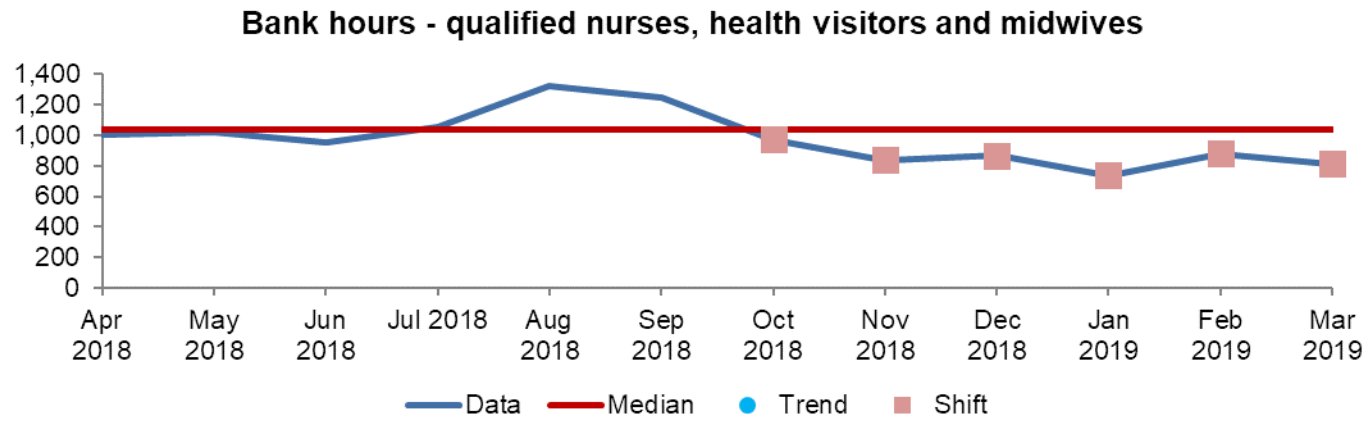
Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a downward trend from July 2018 to January 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Bank staff usage



Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives shows a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing Bank and Agency tab)

Medical staffing

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

Medical staff we spoke to were happy with the medical staffing for consultants, surgeons and trainees within the division. Trainee staff we spoke to were hoping a vacancy would open so they could apply to work at the hospital.

The service had an orthopaedic and anaesthetic consultant on call during evenings and weekends. However, there was limited orthogeriatric consultant cover and this gap was filled by medical consultants. We were told there was a business case to fund additional posts but there was a national shortage of this specialised role.

Sickness rates for medical staff were low.

Trust level

The table below shows a summary of the medical staffing metrics in surgery at trust level compared to the trust's targets, where applicable:

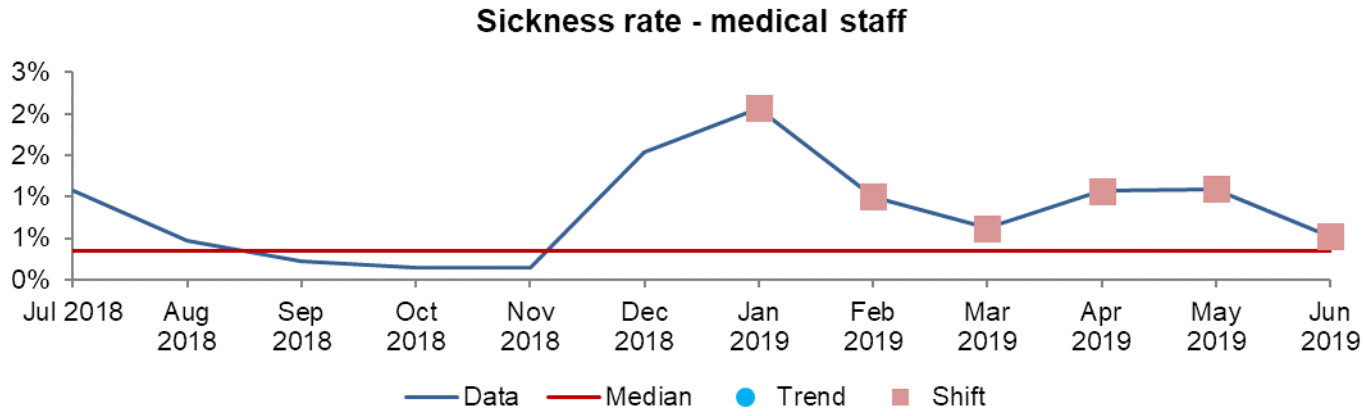
	Surgery annual staffing metrics July 2018 – June 2019						
Staff Group	**Annual average**	**Annual vacancy**	**Annual turnover**	**Annual sickness**	**Annual bank**	**Annual locum**	**Annual unfilled**

	establishment	rate	rate	rate	hours (% of available hours)	hours (% of available hours)	hours (% of available hours)
Target		4%	9%	4.0%			
All staff	1,217.2	8%	12%	4.7%			
Medical staff	240.1	12%	6%	0.8%	9,026 (2%)	9,234 (2%)	18 (<1%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and turnover.

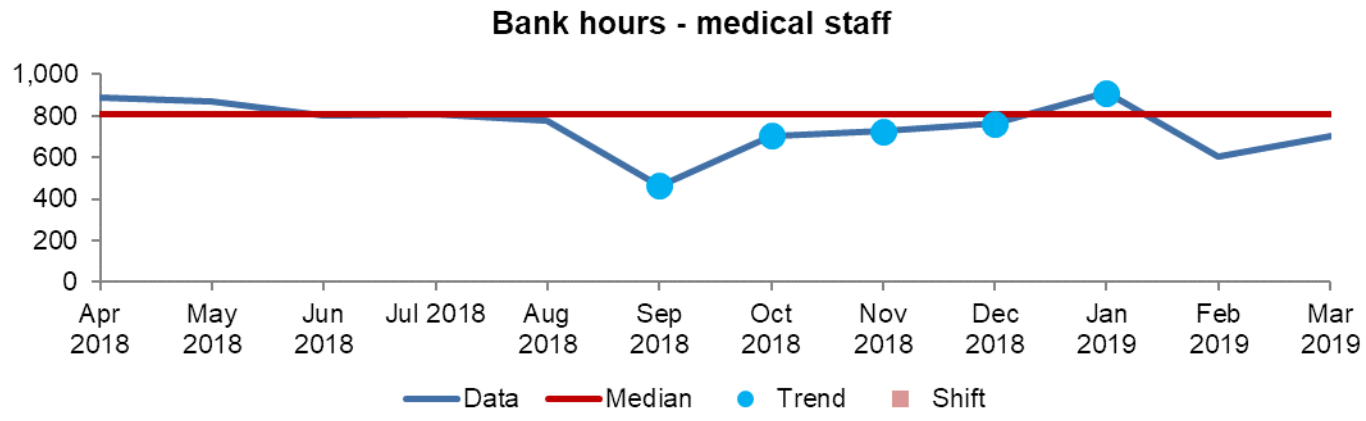
Sickness rates



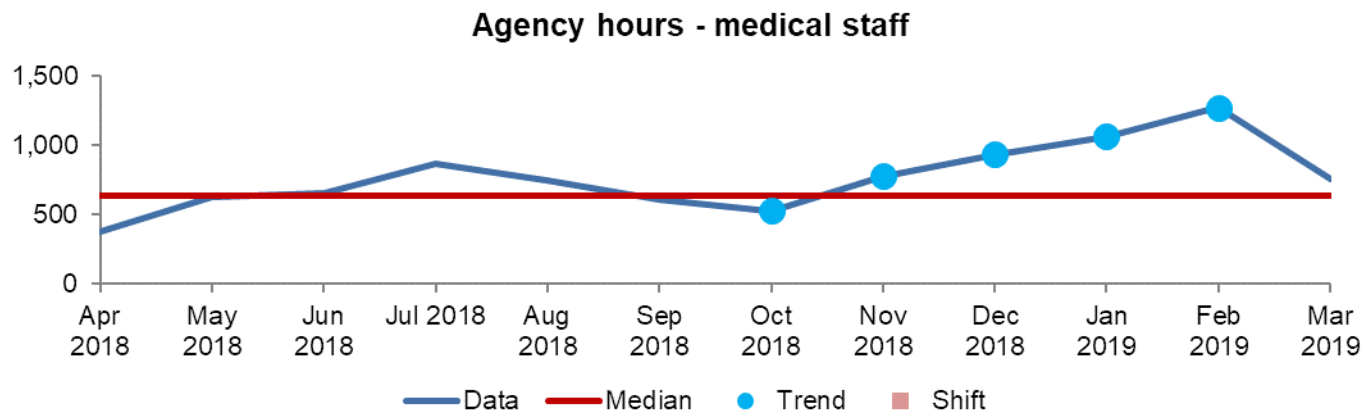
Monthly sickness rates over the last 12 months for medical staff shows a shift from January 2019 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage



Monthly bank hours over the last 12 months for medical staff shows an upward trend from September 2018 to January 2019.



Monthly agency hours over the last 12 months for medical staff shows an upward trend from October 2018 to February 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

Wrightington Hospital

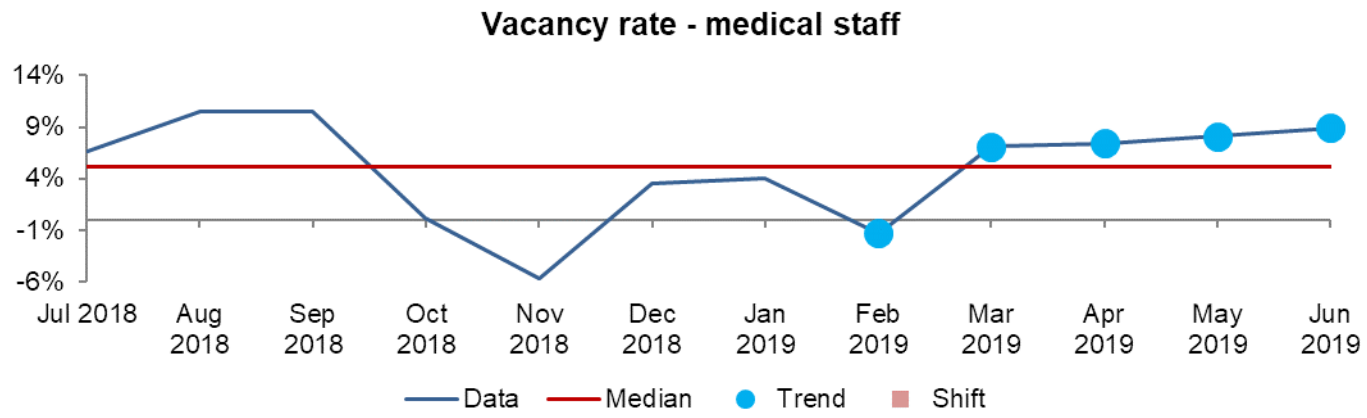
The table below shows a summary of the medical staffing metrics in surgery at Wrightington Hospital compared to the trust's targets, where applicable:

	Surgery annual staffing metrics July 2018 – June 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours**	**Annual locum hours**	**Annual unfilled hours**
Target		4%	9%	4.0%			
All staff	602.2	6%	11%	5.4%			
Medical staff	86.5	5%	2%	0.7%	5,041	2,931	0 ()

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within surgery at Wrightington Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank use.

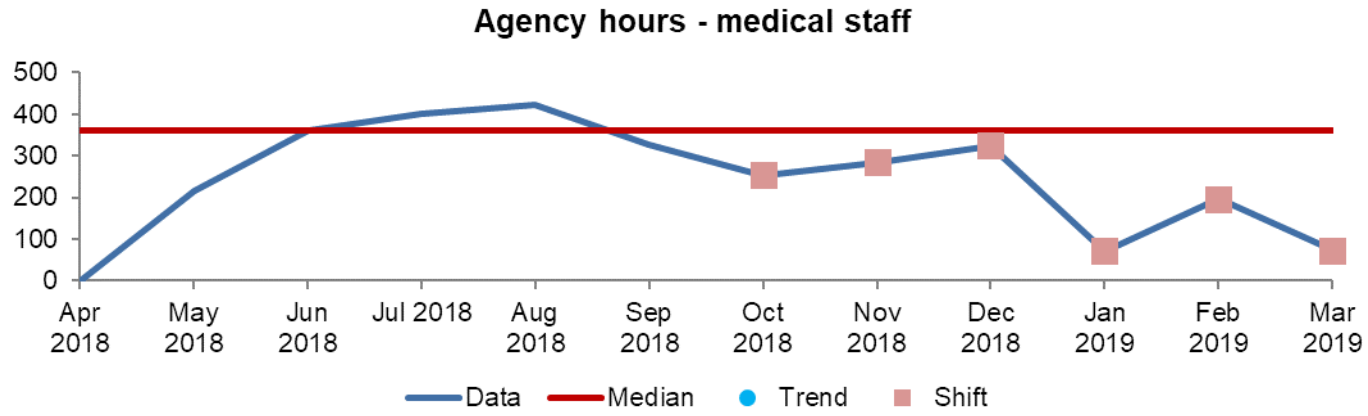
Vacancy rates



Monthly vacancy rates over the last 12 months for medical staff shows an upward trend from February 2019 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Bank staff usage



Monthly agency hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

Records

Staff kept details records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care and treatment. However, we saw records were not stored securely in some areas.

We reviewed four patient records across different wards. Staff used a combination of paper records and an electronic recording system. At the time of our inspection a record transformation project was in progress to move all paper records to the electronic system. Care pathways were paper-based.

Patient records were available to staff in a timely manner and systems were in place for the transfer of records to clinics and wards. When patients transferred to a new team, there were no delays in staff accessing their records. A taxi service was available for urgent transfer of patient notes for ward admissions, if this was needed.

All electronic records were password protected. However, paper records were not always stored securely in some areas. The pre-operative assessment clinic nurses stored patient records on their case load in an unlocked room. We were told by staff this had been escalated and a door locked had been ordered. At the time of inspection this had not been fitted. Although the door was in the reception area there was a potential risk members of the public could enter the room and have access to confidential patient information. On Ward B, patient case files were left on the reception desk unattended on two occasions during our inspection.

Medicines

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

Staff followed current national practice to check patients had the correct medicines. We reviewed ten patient prescription charts and saw allergies were clearly documented and pain relief was prescribed in a timely manner.

Staff stored and managed medicines and prescribing documents in line with the trust's policy. We checked a selection of medicine cupboards and medicines. We found medicines, including controlled drugs were stored securely and documented appropriately. Fridge temperatures were checked and on the occasion the fridge temperature was of concern, this was escalated and actioned in a timely manner.

Incidents

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

Staff raised concerns and reported incidents and near misses in line with trust policy. The trust had an electronic incident reporting system for reporting and managing incidents. Staff received feedback following incidents reported and wider learning from incidents was shared in the daily safety huddles held within the theatre and ward areas. We reviewed quarter two incident report on Charnley ward and saw there had been a recent theme of patient falls. We saw appropriate action had been taken for duty of candour and lessons learnt.

The division monitored performance in incident reporting and investigation. The specialist division governance report for September 2019 identified the number of outstanding investigation reports to be completed within 10 days was 37.

Managers debriefed and supported staff after serious incidents. Since our last inspection the service had had two never events. The service had completed a full investigation of each event and changes were made to the local safety standards for invasive procedures.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to July 2019, the trust reported four incidents which were classified as never events for surgery;

- August 2018: Wrong site surgery (Royal Albert Edward Infirmary): Incorrect teeth removed.
- September 2018 (Wrightington Hospital): Wrong site surgery: Anaesthetic injected to incorrect hip.
- October 2018 (Royal Albert Edward Infirmary): Retained foreign object post procedure: Small piece of Durofibre left in situ following procedure
- December 2018 (Wrightington hospital): Wrong prosthesis: Wrong size prosthesis fitted during hip replacement.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from August 2018 to July 2019.

A breakdown of incidents by incident type is below:

- Five surgical/invasive procedures incident meeting SI criteria
- Three diagnostic incidents including delay meeting SI criteria (including failure to act on test results)
- Two sub-optimal care of the deteriorating patient meeting SI criteria
- One major incident/ emergency preparedness, resilience and response/ suspension of services
- One HCAI/Infection control incident meeting SI criteria
- One treatment delay meeting SI criteria
- One pressure ulcer meeting SI criteria
- One medication incident meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see at the entrance of each ward we visited. This included patient falls, hospital acquired pressure ulcers, MRSA and C-Diff data. We saw that in the main the results were positive.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, seven falls with harm and four new catheter urinary tract infections from August 2018 to August 2019 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Wrightington, Wigan and Leigh NHS Foundation Trust

Total Pressure ulcers (1) [1]

Total Falls (7) [2]

Total CUTIs (4) [3]

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment base on national guidance and evidence-based practice. Staff managed the service in accordance with national guidelines and professional guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Care and treatment was based on national guidelines including National Institute for Health and Care Excellence (NICE) guidelines. The service followed surgical pathways for hip, knee, shoulder and ankle replacements. Other orthopaedic surgical procedures included sports knee injury and arthroscopy. Following surgery patients were recovered in a dedicated recovery area, in accordance with the Association of Anaesthetists guidelines.

Policies and procedures were available on the trust intranet page for all staff, making them easily accessible. Policies appropriately referenced current good practice and national guidelines and documents contained clear guidance, referral flow charts, escalation pathways and other information.

The service participated in the trust's audit programme, with audits compared to recognised standards and guidelines both internally and nationally. Various local audits were completed in different services; these included an audit of cancellations for pain treatments, and audits of benign and malignant prostate conditions.

Patients attended pre-operative clinics and sessions to prepare for surgery and know what to expect. Patients were given information leaflets about their surgery and recovery.

Elective patients where suitable were placed on an enhanced recovery pathway for hip and knee replacement surgery.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other nutritional needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs.

Staff completed patients' fluid and nutrition charts where needed.

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

All patients we spoke to said the food was good and they were offered different choices.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff prescribed, administered and recorded pain relief accurately.

Nurses assessed and recorded patients' pain score and recorded these as part of NEWS documentation.

Patients told us they received pain relief soon after requested it. All patients we spoke to said their pain was managed well and they received pain relief soon after requesting it.

The service had a pain team of consultants and nurses they could refer patients to who had chronic pain.

Patient outcomes

Managers monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers used information from the audits to improve care and treatment. At the time of inspection the service was auditing one day hip replacement pilot scheme. The pilot scheme was for hip replacement day case surgery for patients who did not have co-morbidities or complex needs. There had been 18 patients, of which 14 were discharged the same day, three patients were discharged on day one and one patient had been discharged on day two.

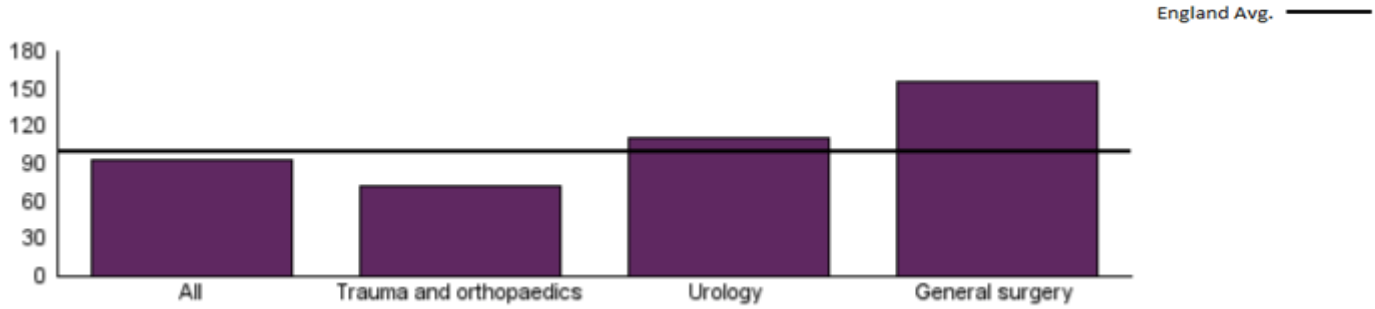
The service had lower than average elective admissions for trauma and orthopaedics.

Relative risk of readmission

Trust level

From February 2018 to January 2019, all patients at the trust had a lower than expected risk of readmission for elective and non-elective admissions when compared to the England average.

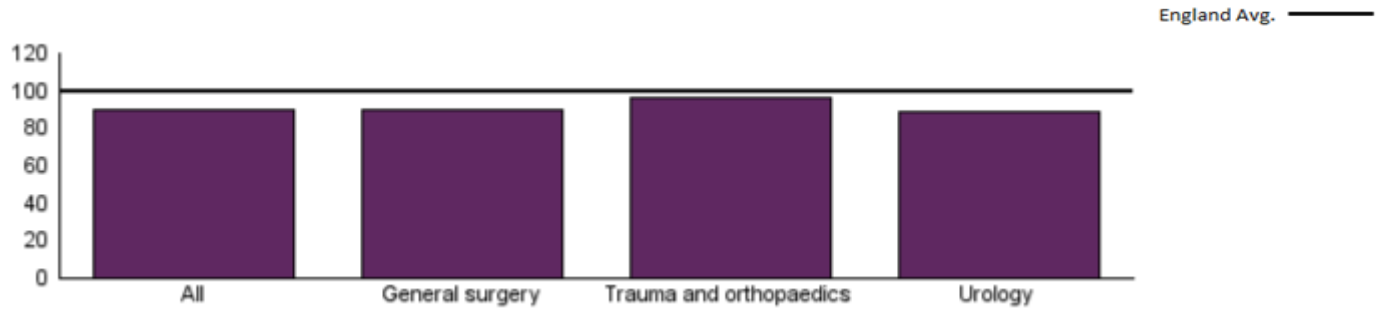
Elective Admissions – Trust Level



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in trauma and orthopaedics had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Patients in urology and general surgery had a higher than expected risk of readmission for elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level



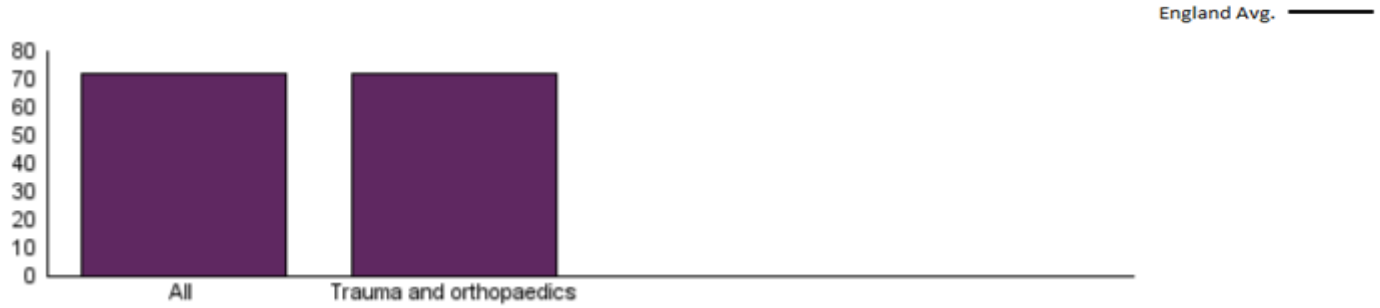
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in general surgery, trauma and orthopaedics and urology had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Wrightington Hospital

From February 2018 to January 2019, all patients at Wrightington Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - Wrightington Hospital



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity
Note – average line is missing from above chart as 100 is not on the axis.

- Patients in trauma and orthopaedics at Wrightington Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

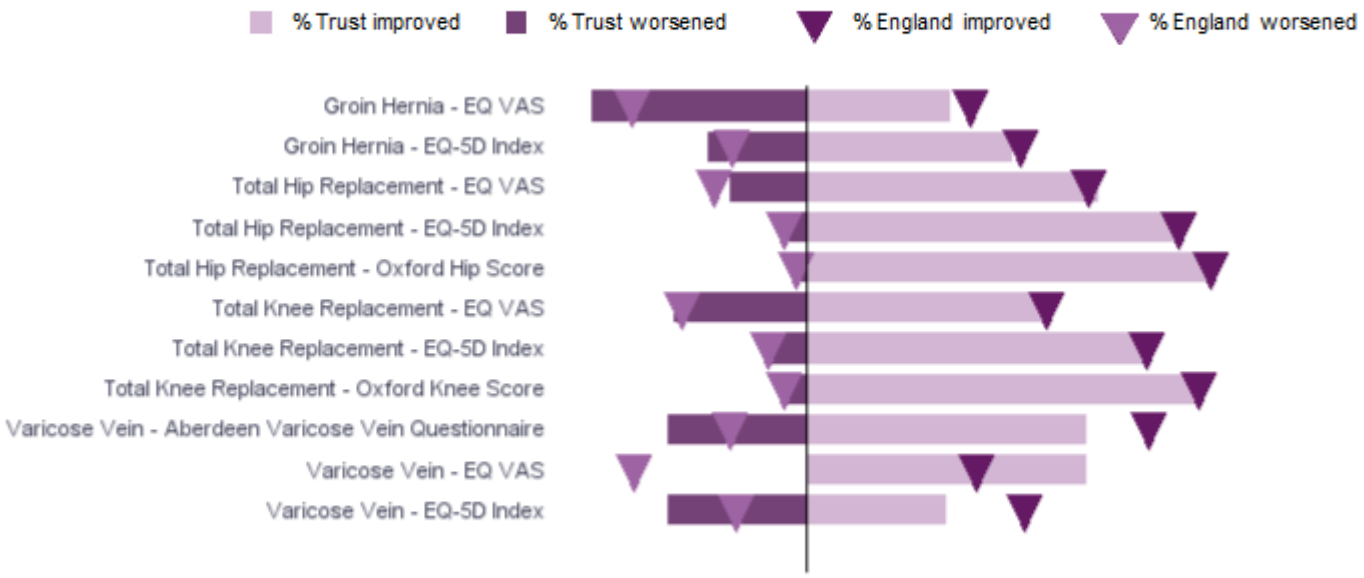
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

Visual analogue scale (EQ-VAS)

Visual analogue scale (EQ VAS) is, asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific Issues namely mobility self-care usual activities pain or discomfort anxiety or depression. The EQ-5D-5L uses 5 levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.



In 2016/17 performance on groin hernias was worse than the England average for EQ VAS and EQ-5D index.
For Varicose Veins, performance was worse than the England average for Aberdeen Varicose Vein Questionnaire and EQ-5D index, but for varicose vein EQ VAS trust performance was better than the England average.

For hip replacements, performance was about the same as the England average for all three measures.

For knee replacements was about the same as the England average for all three measures.

(Source: NHS Digital)

Competent staff

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

Managers gave all new staff a full induction tailored to their role before they started work. New staff were supernumerary to the rota for a defined period or longer if required.

Managers made sure staff received any specialist training for their role. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Training needs of staff were identified and reviewed during annual staff appraisals

and a personal development plan was agreed.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff we spoke with confirmed they had received training for their role and this was reviewed at their annual appraisal.

Managers identified poor staff performance and supported staff to improve. Staff gave examples of this on inspection and how staff were supported. The ward and theatre areas had link nurses to support staff in areas such as dementia, sepsis, pain, alcohol, tissue viability, infection prevention and control. These members of staff received additional specialist training for their role which they cascaded to staff within their area. The link nurses also attended regular meetings led by the trust lead for their role to share experience, develop supporting training materials/information and keep up to date with national guidance and best practice.

Appraisal rates

Trust level

From April 2018 to March 2019, 83.5% of required staff in surgery at trust level received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the tables below:

Staff group	Staff who received appraisal	Eligible staff	Completion rate	Trust Target	Met (Yes/No)
Administrative and clerical	96	109	88.1%	90%	No
Allied health professionals	56	66	84.8%	90%	No
Nursing and midwifery registered	308	365	84.4%	90%	No
Healthcare scientists	10	12	83.3%	90%	No
Additional clinical services	223	273	81.7%	90%	No
Add prof scientific and technic	33	44	75.0%	90%	No

Wrightington Hospital

From April 2018 to March 2019, 84.4% of required staff in surgery at Wrightington Hospital received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the tables below:

Staff group	Staff who received appraisal	Eligible staff	Completion rate	Trust Target	Met (Yes/No)
Allied health professionals	41	47	87.2%	90%	No
Administrative and clerical	39	45	86.7%	90%	No
Nursing and midwifery registered	148	172	86.0%	90%	No
Additional clinical services	111	135	82.2%	90%	No
Add prof scientific and technic	17	23	73.9%	90%	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Wards had daily multidisciplinary meetings which we observed on inspection. Representatives from the discharge team, ward staff and supporting services attended the meetings and all relevant information was discussed. We observed positive discussions which demonstrated good team working and a collective approach to patient care.

The allied health professional team supported patients following a referral from the wards. We saw there was a strong and close working relationship between the physiotherapy, occupational therapy, ward, pharmacy and discharge teams focused on recovery and patient centred care.

The discharge team worked to build relationships with external organisations for timely discharge planning especially for patients who lived out of the hospital area.

Seven-day services

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

The service provided pre-operative and elective surgery Monday to Friday at the Wrightington site. Theatre lists were staffed from 8am until 7pm depending on the surgery case load. Additional Saturday theatre lists were added when required.

The ward areas were open seven days a week, twenty four hours a day. Consultants led daily ward rounds on all wards. An on call rota for anaesthetics and orthopaedic surgeons provided an out of hours service.

The orthogeriatrician service was not a seven day service due to staffing shortfalls. We were told a business case was in progress to fund additional posts but national recruitment was a concern for the specialist role.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. Different leaflets were available providing information about specific individual procedures such as knee and hip replacement surgery.

Staff assessed patient's health as part of the pre-operative assessment and provided support for any individual needs to live a healthier lifestyle. Patients were referred to a physiotherapy session pre-operatively for information and exercises to prepare for surgery. Depending on their individual needs, patients could be referred or signposted to alcohol liaison or stop smoking services.

Service leads told us plans were in development for health promotion pathways such as anaemia. This was linked into service planning development depending on the national network developments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patents' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff followed the trust's consent policy and documentation for patients undergoing surgery. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We saw evidence of this on inspection where best interest meeting had taken place and two clinicians had signed to consent a patient with dementia.

Staff understood how and when to access whether a patient had the capacity to make decisions about their care.

Wards and theatres had link nurses for Mental Capacity Act and Deprivation of Liberty Safeguards. There were also nominated champions and leads within the trust who could be contacted for further assistance and support if needed.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Trust level

The trust set a target of 95% for the completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training modules from April 2018 to March 2019 at trust level for qualified nursing staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained /compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	424	455	93.2%	95%	No

A breakdown of compliance for MCA training from April 2018 to March 2019 at trust level for medical staff in surgery is shown below:

Training module name	April 2018 to March 2019				
	Staff trained / compliant	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	95	163	58.3%	95%	No

Data was not available for Wrightington Hospital.

Is the service caring?

Compassionate care

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

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw evidence of this on inspection. Patients told us how their needs had been met with compassion, kindness and respect.

We observed staff interacting with patients and relatives in a caring manner. We observed the call bells were responded to in a timely manner.

Staff spent time with patients to ensure care was not rushed; care was delivered with kindness, compassion and understanding, which extended to include patients' relatives and carers.

The trust offered chaperones for patients who wished to have this; we saw signs displayed to promote the service.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff were sensitive to the emotional needs of patients undergoing surgical procedures and their concerns about risks and complications of surgery.

Patients told us staff were positive about the care given and that this helped them in their experience of hospital care.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff supported patients to make informed decisions about their care. Staff conducted best interest meetings where appropriate with the patients relatives.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

We spoke with seven patients who all said they were able to ask questions about their care and treatment. Staff explained what would happen during their visit and what to expect during and after surgery and provided information booklets to help answer questions patients may have when they went home. Patients told us they were given a contact number to phone if they had any further questions when they went home.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of the local people and communities served. It also worked with others in the wider system and local organisations to plan care. However, wheelchair access to the pre-operative assessment unit was difficult.

Managers planned and organised services so they met the needs of the local population. The specialist services division were clear that their main aim was to provide accessible services for the local population. In addition, they also provided more complex innovative orthopaedic services which served the wider population of Greater Manchester, Cumbria and Lancashire.

The service worked closely with local and regional commissioning groups to plan and develop services. There were discussions in progress to work with other trusts to centralise orthopaedic services within the region. However, this was dependent on decisions made within the wider health economy.

The service had a dedicated unit for self-paying orthopaedic patients. The unit consisted of a ward and pre-operative clinic which was run by the trust. Every patient had a private room on the ward.

At the time of our inspection service leads were working toward a business plan to extend services at the hospital within the wider health economy. This included having a level two critical care unit on the Wrightington site.

Meeting people's individual needs

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

Wards were designed to meet the needs of patients living with dementia and patients living with dementia were supported according to their individual needs. A forget-me not flower symbol on patient notes and magnet on the patient's bed board would prompt staff to be aware of their additional needs. We were told patients could arrange to visit the ward before admission to see the environment and meet staff. This helped to familiarise patients with the hospital ward and reduce anxiety of admission.

Patients with individual needs would be identified during their pre-operative assessment and this information would flag to the ward for assessment. Wherever possible a side room would be offered for patients living with dementia or learning disabilities, to allow relatives and carers to be close to them. Patients were encouraged to visit the ward before admission to familiarise themselves with the layout and facilities before admission.

Staff described good access to resources to support patients who were living with dementia. All staff attended a two day dementia awareness course as part of their mandatory training. There was a dementia care bundle box which staff could access, and they used "this is me" booklets which had been created by a national dementia charity. The booklets enabled the patient and their family to document their likes, dislikes and care needs.

Wards and theatres had a number of different link nurses who had an interest and additional training in certain areas. We saw that there were link nurses for learning disabilities, dementia, alcohol and deprivation of liberty standards. These staff cascaded training and information to the ward team and were there to support those looking after patients with additional needs.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients we spoke to confirmed this.

Patients told us that staff were supportive of their individual circumstances and needs, especially been away from family members and helped them stay in contact with family members. The service provided equality and diversity training as part of staff mandatory training. Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Written information was displayed in English language formats, although staff could arrange for alternative language translations where this was needed. The service had access to the trusts interpreter and translation services for patients whose first language was not English.

Ward staff could access speciality equipment for patients when they needed it such as bariatric equipment. Specialist orders for prosthetics and other surgical equipment was arranged by patient need.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards and much better than the national average.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Access to the service was by referral from the patient's GP or local hospital for NHS and private patients. At the time of inspection work was in progress with other hospitals to refer patients before the pre-operative assessment so complex patients would be picked up in a timely manner by the service.

Managers and staff worked to make sure patients did not stay longer than they needed to. We observed morning ward multidisciplinary and bed management meetings. We saw positive working relations between staff to accommodate the access and flow needs of the service.

Managers worked to keep the number of cancelled operations to a minimum. The number of short notice cancelations for operations was higher than the national average and we were told this was due to referrals from other hospitals where additional needs had not been identified as the pre-operative assessment was completed at the referring trust. Plans were in progress to complete pre-operative assessments for all patients having surgery at the Wrightington site at Wrightington pre-operative assessment clinic.

Managers and staff worked to make sure that they started discharge planning as early as possible. Approximately 70% of patients treated at the hospital lived out of the hospital area. The discharge form was completed on the ward. We were told it was sometimes difficult to organise patients discharge depending on the location the patient resided. Staff told us they had built up good rapport with other services and contact lists based on the patient's postcode for GP and funding.

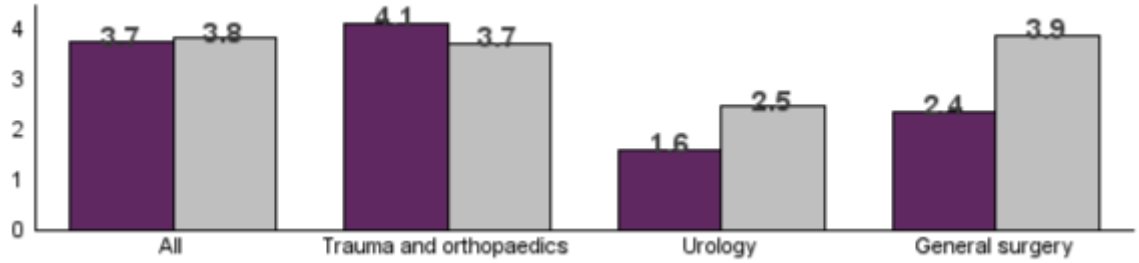
Managers monitored patient transfers and followed national standards.

Average length of stay

Trust Level

From March 2018 to February 2019 the average length of stay for all surgical elective patients at the trust was 3.7 days which is similar to the England average of 3.8 days.

Elective Average Length of Stay – Trust Level



Note: Top three specialties for specific trust based on count of activity.

Average length of stay for elective specialties:

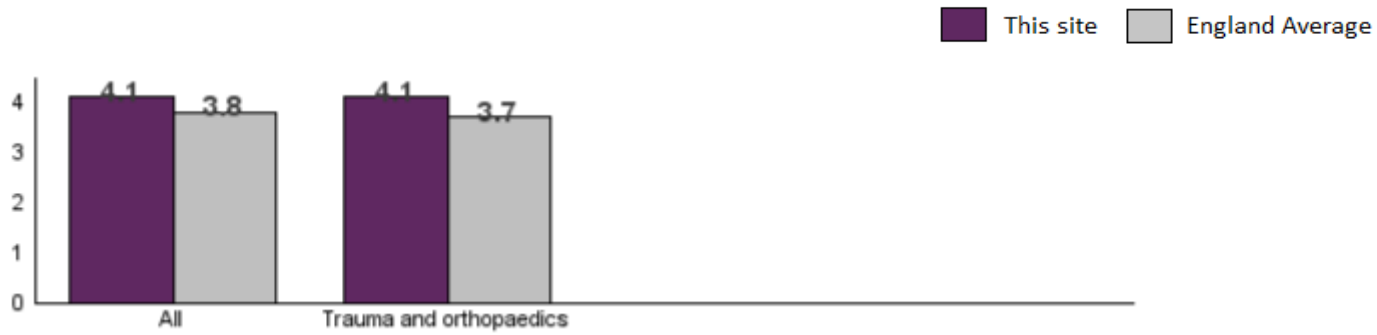
- Average length of stay for elective patients in urology and general surgery is lower than the England averages.
- Average length of stay for elective patients in trauma and orthopaedics is similar to the England average.

Wrightington Hospital

From March 2018 to February 2019 the average length of stay for all surgical elective patients at Wrightington Hospital was 4.1 days, which is similar to the England average of 3.8 days.

Following the inspection the trust provided us with information which showed between April 2019 and September 2019 the average length of stay was 3.5 days.

Elective Average Length of Stay - Wrightington Hospital



Note: Top three specialties for specific site based on count of activity.

Average length of stay for elective specialties:

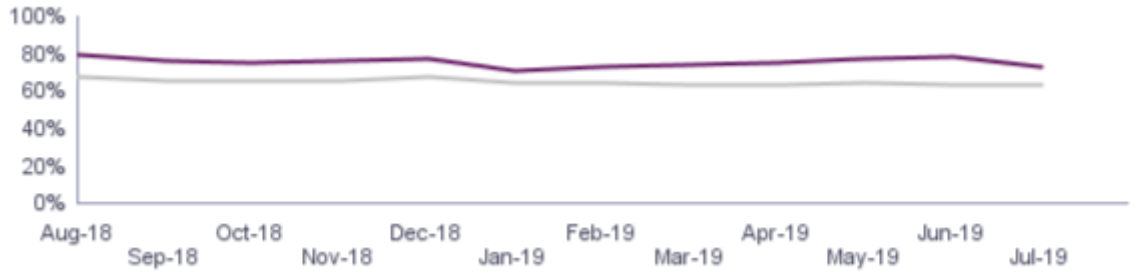
- Average length of stay for elective patients in trauma and orthopaedics is similar to the England average.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From August 2018 to July 2019 the trust's referral to treatment time (RTT) for admitted pathways for surgery was consistently higher than the England average.

Trust performance ranged from 70.6% to 79.0% compared to the England average, which ranged from 63.3% to 68.3%.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Four specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Plastic surgery	93.9%	78.9%
Trauma & orthopaedics	84.0%	58.4%
Ear, nose & throat (ENT)	72.1%	60.0%
Oral surgery	59.1%	55.2%

Three specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Urology	64.3%	74.9%
Ophthalmology	49.9%	62.2%
General surgery	49.2%	72.1%

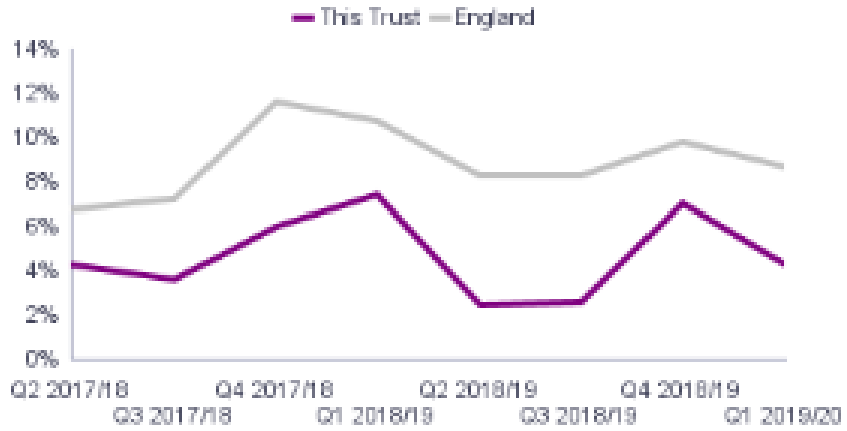
Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

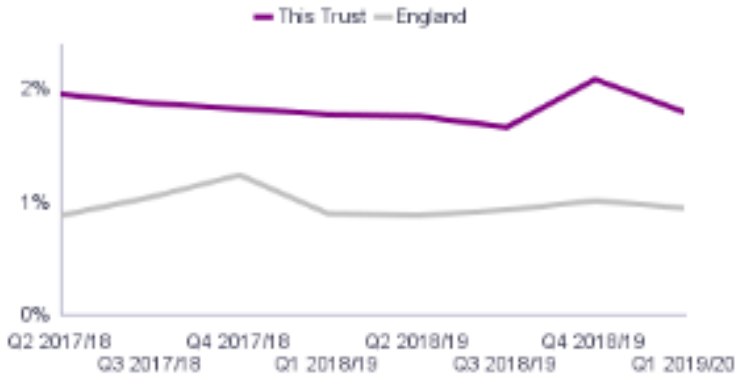
Over the two years, the percentage of patients with cancelled operations and not treated within 28 days has been consistently lower than the England average. Trust performance has ranged between 2% and 7% across the period.

In the latest quarter, Q1 2019/20 the trust cancelled 208 surgeries, and of those cancellations 4% of patients weren't treated within 28 days. The trust informed us that of the cancellations 50 were at Wrightington Hospital, and of those one was not treated within 28 days (2%).

Percentage of patients whose operation was cancelled and were not treated within 28 days - Wrightington, Wigan and Leigh NHS Foundation Trust



Cancelled Operations for non-clinical reasons as a percentage of elective admissions - Wrightington, Wigan and Leigh NHS Foundation Trust



Over the two years, the percentage of cancelled operations as a percentage of elective admissions at the trust has been consistently higher than the England average.

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

The trust reported that between April and July 2019 at Wrightington Hospital 50 operations were cancelled for non-clinical reasons on the day which equated to 1.5% of operations.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service clearly displayed information about how to raise a concern in patient areas. Each ward had an information board at the entrance for who to contact if patients, relatives and carers wanted to make a complaint.

Divisional managers monitored complaints and this was reported in the divisions monthly quality report. For September 2019 three orthopaedic complaints had been received.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Summary of complaints

Trust level

From July 2018 to June 2019 the trust received 118 complaints in relation to surgery (22.6% of total complaints received by the trust).

The trust's complaints and concerns standing operating procedure sets out the different timescales for responding to complaints depending on the complexity of the complaint and issues raised. The agreed response times are 30 days, 40 days, 60 days or 90 days. The trust took an average of 52.1 working days to investigate and close complaints.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	49	41.5%
Patient care	20	16.9%
Communications	13	11.0%
Admissions & discharges (excl delayed discharge due to absence of a care package)	13	11.0%
Appointments	8	6.8%
Waiting times	5	4.2%
Values and behaviours (staff)	3	2.5%
Prescribing	2	1.7%
Pdw	1	0.8%
Trust admin policies procedures incl patient record management	1	0.8%
Facilities	1	0.8%
Access to treatment or drugs	1	0.8%
No subject given	1	0.8%
Total	**118**	**100.0%**

Wrightington Hospital

From July 2018 to June 2019 the trust received 29 complaints in relation to surgery at Wrightington Hospital (24.6% of total surgery complaints received by the trust).
The trust took an average of 48.8 working days to investigate and close complaints, this is not in line with their complaints policy of 30 working days to complete complaints.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	10	34.5%
Communications	8	27.6%
Patient care	4	13.8%
Values and behaviours (staff)	2	6.9%
Waiting times	2	6.9%
Admissions & discharges (excl delayed discharge due to absence of a care package)	1	3.4%
Access to treatment or drugs	1	3.4%
Prescribing	1	3.4%
Total	**29**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From July 2018 to June 2019 there were 416 compliments received for surgery at the trust (13.3% of all received trust wide).

A breakdown of compliments by type and ward area is shown below:

Ward/Area	Beverages	Biscuits	Chocolates	Card/ Letter Thank You	E-mail Thank you	Telephone Thank you	Total
Ward One, Wrightington Hospital		44	40	41		56	**181**
Langtree Ward, RAEI	10	50	50	101	3		**214**
John Charnley Wing, Wrightington Hospital	2	3	6	10			**21**
Total	**12**	**97**	**96**	**152**	**3**	**56**	**416**

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Although leaders had the, skills and abilities to run the service. Senior leaders were not always visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Staff we spoke with were positive about their immediate leadership in the ward managers and senior theatre co-ordinators and lead nurses. However, nursing and support staff on the wards reported that there was little visibility from the senior leadership team in the division and trust wide.

We spoke with divisional leaders of the service who had an understanding of the issues the service faced as a whole. Leaders recognised and were aware of the regional system-wide issues that had an impact on the future service development. There was uncertainty about where services would be provided from which delayed the decision making process for local plans and progress.

The senior leadership team for the specialist services division identified that they did not have concerns about the medical and nursing workforce and felt that recruitment and retention was positive. They were aware of national shortages in certain roles and had an overseas recruitment program. The senior medical team described as proactive approach to developing staff for senior medical roles.

Nursing and medical staff we spoke with felt their development was supported and that there were opportunities to take on additional responsibilities and training.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn this into action, developed with all relevant stakeholders. The vision and strategy were dependent on progress in regional developments within the wider health economy. Leaders and staff understood the trust's vision and strategy and knew how to apply this in monitoring progress.

Surgical leads were aware of external influences, such as the transformation of social care and the uncertainty around changes creating challenges to planning. The specialist service division had a vision for what it wanted to achieve which senior leaders told us was to become the leading orthopaedic centre for Greater Manchester. There were plans to develop the Wrightington site and expand services at the location. The service worked closely with commissioning groups locally and regionally to develop and expand services. The service was part of the Greater Manchester Orthopaedic Alliance and the future developments depended on decisions made regionally about how services would be delivered. At the time of inspection the future development plans were not finalised.

The trust promoted a vision to make a positive difference to people's lives. Staff we spoke with had embraced this vision and demonstrated behaviours which were in accordance with the trust values.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided

opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke to were proud to work for the organisation and their department. Overall the culture within the service was positive.

Staff we spoke to had seen improvement in divisional staffing levels over the last 12 months. There had been staffing shortages and managers had addressed this by moving staff from Wrightington site to work at Royal Albert Edward infirmary to provide safe staffing for trauma services. The specialist services division managers recognised working in an elective setting and an acute setting had left staff feeling concerned and this was reflected in staff survey results. Senior staff told us they worked across site to support staff and provide visibility. Nurse working groups were being integrated and standardised so they were the same across both sites and could meet as one team where possible.

Main theatre staff had a positive and resilient culture despite the issues with the fabrication of the environment. There was a strong team working spirit and local leaders praised staff for their positive attitude whilst they were waiting for improvements to be made.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Orthopaedic surgery sat within the specialist services division led by a divisional medical director and divisional director of operations. They were supported by a senior human resources business partner and divisional accountant. There was an established governance structure for accountability and information flow between committees from floor to board.

The division created a monthly governance report which contained information about service performance, audit outcomes, incidents, duty of candour, risk, complaints, national guidance updates, mortality and morbidity. These reports were available for staff to read and discussed in staff meetings. The September 2019 showed direct care (patient safety incident) was the top theme and trend with 39 incidents.

Some of the divisional committees included T & O clinical audit meeting, health and safety meeting, new procedures group, policy risk and review, and surgical site infections.

There were established trust committee structures for monitoring clinical quality and patient safety. Service performance and audit outcomes were monitored on a regular basis, with improvement actions identified and progress measured.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. However, they did not record the risks in relation to the fabrication and environment of the older theatre area in a timely manner. Longstanding risks had only been recorded shortly before the inspection and there were limited plans detailing the actions to reduce and mitigate the risks.

We were told when risks were identified risk assessments were completed as per the trust risk management process policy TW10-002 SOP 1.

Risk registers were reviewed at monthly quality and safety meetings. Senior staff including governance leads, consultants, matrons and ward managers attended these meetings, to review relevant issues, the risk register, safety incidents and performance.

During our inspection we reviewed the trust risk management policy which detailed the trust strategy, responsibility and committee roles for managing risk. Since our last inspection the risk assessments were in the process of being added to the IT incident system risk module. Risk registers were held locally and any risk above a moderate risk were escalated to the divisional risk register. High risks were escalated to the corporate risk register.

Divisional leaders and managers had good awareness of service risks and could provide current updates of the actions to reduce these. However, during our inspection we found risk management escalation had not been completed in a timely manner for the fabric and environment of main theatre, two, three, four and nine. At the time of inspection the risk was still in the process of going through the divisional approval process for escalation. One risk assessment had been completed for all the fabrication building and environmental risks had been completed 15 October 2019 and reviewed 30 October 2019 after our inspection. The risks had been escalated to board the week prior to our inspection. Post inspection we requested any preceding risk assessments for Wrightington orthopaedic theatres and none were provided. The trust gave information for the history of the flooding that had occurred and actions taken to reduce the risk of flooding.

The service had business continuity plans and major incident processes and procedures which were seen on inspection.

Information management

The service collected reliable data and analysed it. Managers could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected relevant information they needed to monitor performance and to ensure there was sustained improvement. Clinical staff had access to patients' investigation results and there were no concerns regarding any delays in receiving these.

Staff had access to important information, such as policies and other guidance on the trust's intranet. Safety alerts and meeting minutes were displayed on notice boards in staff areas and discussed in safety huddles to keep staff up to date and aware of issues.

The service used different IT systems for activities and there were no concerns regarding the availability of these systems.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The senior nursing staff in the theatre team told us they were part of the Northwest Theatre Managers Consortium and they attended meetings on a bi monthly basis where there was representation from seven trusts. We were told that the meetings discussed national issues and any changes or updates to working practices. In addition, they undertook audits on a quarterly basis to benchmark practice across the region

The trust's brochure 'Your stay with us' was provided to each patient on their admission. This outlined the trust's services and details of what patients could expect during their admission. The division's monthly quality report identified increased performance in patient engagement survey results during September 2019, with 11 out of 12 green scores and one red score. Ten of the questions had increased in their percentage scores compared to August's results.

The trust engaged with volunteers, who we saw were managing hospital's the main entrance reception desk during the inspection.

The trust had a Freedom to Speak Up Guardian and staff were aware of their role; during our inspection the trust was promoting Freedom to Speak Out month.

Learning, continuous improvement and innovation

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

The orthopaedic clinical leads told us the service had published more than twenty research papers in the last 12 months to share learning nationally. In addition, the team ran medical training courses for external staff to share best practice.

At the time of inspection, a one day case hip replacement pilot scheme was in progress. More than twenty day surgery hip replacements had been performed. The service was auditing patient outcomes and had presented initial findings at a recent conference.

The upper limb service was keen to use technology for surgical improvements such as muscle testing. We were told on inspection that a business case was in development as financial investment was needed to purchase the additional equipment.

The upper limb service was using quality improvement principles to make improvements to the service. This had involved engagement and the involvement of staff who worked in the areas to improve the service.

The trust had coaching and mentoring scheme which was promoted for staff to access and use.

Each ward had link nurses for a number of specialist areas such as dementia, sepsis, alcohol, medicines management to support ward staff.

The ward and theatre areas had quality improvement boards called 'myQ' for simple ideas to make improvements to services. We saw some of these had been implemented and had contributed to improving the service.

The service held regular mortality and morbidity meetings which had a learning approach and aimed to identify areas for improvement. We were given an example of how practice had been improved as a results of these reviews.

The service won an award for best poster for hand therapy at the British Association of Hand Therapists annual conference.