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 hospital sites at the trust

A list of the acute hospitals at the trust is below:

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arroewe Park</td>
<td>Arroewe Park Road, Upton, Wirral, Merseyside CH49 5PE</td>
<td>Delivering a full range of emergency and acute services for adults and children, plus maternity services</td>
<td>Wirral</td>
</tr>
<tr>
<td>Clatterbridge</td>
<td>Clatterbridge Road, Bebington, Wirral, CH63 4JY</td>
<td>Undertaking the majority of planned surgical services and some specialist rehabilitation</td>
<td>Wirral</td>
</tr>
</tbody>
</table>

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

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

The other site is Clatterbridge Hospital in Bebington and provides surgical and medical rehabilitation services together with some outpatient services.

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

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

Wirral University Teaching Hospital NHS Foundation Trust was last inspected in September 2015 and rated requires improvement overall. We inspected the trust on 1 to 3 May 2018 to assess the well-led aspect of the trust.
Is this organisation well-led?

Leadership

Board Members

Of the executive board members at the trust, there were no British Minority Ethnic (BME) and 66.7% were female.

Of the non-executive board members there were no BME and 50.0% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>57.1%</td>
</tr>
</tbody>
</table>

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

Since our last inspection the trust had a leadership team that had under gone significant changes to executive leaders, this had led to a lack of stability; with both the chief executive and chairman resigning from the trust with immediate effect a few months before this inspection. There had also been a number of non-executive directors who had recently resigned and the posts had not yet been recruited into. During the inspection, we were informed that a further two directors would be leaving the trust; the medical director and the director of strategy and transformation.

The director of nursing had been on long term sick leave and the trust had put in place an interim director of nursing who had left at the end of January 2018. The director of nursing had returned to work in the middle of March 2018. The director of corporate affairs had been on long term sick leave since the end of 2017 but the trust had only recently sought support from a neighbouring trust. This had just commenced at the time of the well-led inspection.

Whilst the majority of the remaining leadership team had the skills and abilities to provide high quality effective services, key positions were interim. This affected the pace and capability to progress improvements and standards in care provided. Members of the leadership team did not always describe the team as unitary or always working as a whole.

The key posts that were interim were:

- Interim chief executive
- Interim chair
- Interim director of workforce

There was also a member of the leadership team who was fulfilling the role of Interim director of quality governance.

The director of pharmacy and medicines management was the trust’s accountable-officer reporting to the medical director, working as a member of the trust board of directors and providing leadership for trust-wide projects. Following trust re-organisation, the new structure meant medical
optimisation sat under the medical director portfolio whilst the day to day pharmacy service had been aligned to the division of clinical support.

The divisions had also recently seen changes in leadership although this was planned it had affected capacity and capability. This was a challenge for the trust to ensure they had all the assurances for the board. Senior leaders recognised that ward managers had not always been supervisory and included in numbers of available nurses on ward to deliver care.

We saw no evidence of succession planning for the trust leadership team and there had been limited identification of development opportunities for the future of the organisation. Plans had been put in place to ensure there were leadership opportunities for the leadership team and the divisional leaders but they were in their infancy and had not yet been implemented. There had not been a programme of board development or team building for the executive team, however there had been a recent board development day arranged by the interim chair. This was the first one of its kind.

There was no formal leadership strategy in place at the time of the inspection though staff in the divisions had accessed a range of vocational qualifications, which included leadership, but this approach had been inconsistent and not further developed. We were shown plans to address this issue but they had not been implemented at the time of the inspection. This included a three day leadership programme with external speakers.

The executive team were aware of the importance of the visibility of the senior and middle management teams. Since the last inspection, the programme of visits to clinical areas had ceased until recently. Most executive and non-executive directors had a programme of visits to clinical and non-clinical areas. We saw evidence of dates when visits had taken place. We observed an executive director working alongside colleagues in the canteen during the inspection.

Managers and leaders we spoke with told us they tried to maintain visibility in clinical areas. Some staff in clinical areas confirmed they had seen the board members but this was not consistent. We did not observe executives in clinical areas during the inspection.

Whilst staff acknowledged that there had been improvements in the working relationships between the executive team and the divisions, medical staff told us that there was poor engagement with the executive team. Equally, the executive team told us that they had struggled to engage with the medical board.

At the time of the inspection, we were told that the substantive director of quality governance role had been put on hold whilst a further review of the structure took place.

The trust was not fully 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 policy and procedure for all non-executive and executive directors. This had been approved in July 2015. The procedure detailed the requirements in accordance with the regulation. However, it outlined only certain executives and all non-executives were checked in line with the regulation not all directors. We were told that the policy was currently being redrafted and would include all directors and associate directors in the trust. We reviewed the draft policy and found that this still did not include all directors, though did include all associate directors along with all non-executive directors.
As part of the policy and procedure there was a pre-employment fit and proper persons file checklist that had been in place since 2015. This included the checks required including insolvency, bankruptcy and disqualified directors register checks. The checklist was then to be signed by the chairman, director of governance and director of workforce. However, this had not been completed in any of the files we reviewed.

There was no audit process completed to monitor compliance with the fit and proper person’s requirements. The policy also stated that the person responsible for the procedure was the associate director of governance; however, staff informed us that this was actually the responsibility of the director of corporate affairs. Therefore, we were unsure who was responsible for completing the checks in line with trust policy and the regulation.

We reviewed 17 personnel files for executive directors, non-executive directors and board directors and found these to be inconsistent in compliance with the regulation and trust policy. Twelve did not have up to date annual declaration forms. One annual declaration form had been signed but had no date. All directors had a disclosure barring check completed. There was a spreadsheet stating that insolvency and bankruptcy checks had been completed for all but one of the files we reviewed but the trust were unable to provide evidence when these had been completed and if they had actually been done. The trust policy stated that these checks should be completed on an annual basis on 31st March.

We were told that one of the interim directors was fulfilling the function of this role but did not have a personal file and there was no evidence that fit and proper person’s checks, or employment checks, had been completed as they were contracted on a consultancy basis outside of the trust recruitment processes. This was also the case for another person fulfilling the role of an associate director. They had been in post since May 2017 and had been either in attendance at board committee meetings, or members of the trust clinical governance group, with responsibility for implementing actions to improve services.

This meant that the trust could not ensure that people who had director level responsibility for the quality and safety of care, and for meeting the fundamental standards, were fit and proper to carry out these important roles.

The trust had in place a service level agreement with a local mental health provider to ensure there was a psychiatric liaison service.

**Vision and strategy**

The trust had in place a set of values and there were visible displays throughout the trust of the values. However, not all staff we spoke to were able to explain what the values meant to them. This had been recognised by the board who were refreshing the values and behaviours. They had recently engaged with staff and had received a response from 500 members of staff.

The vision of the board was to be locally focused and regionally significant and to be the first choice healthcare partner to the communities they served – from home to the provision of regional specialist centres. We were provided with information that there had been a discussion at the April 2018 board meeting regarding the development of a new strategy for the trust. One of the
actions was that work would commence on the development but would only be finalised following the appointment of a permanent chief executive and chairman. We also saw evidence that strategic planning had been discussed at the March 2018 private board meeting.

The trust had in place an operational plan on a page for 2017 to 2019. This outlined the strategic aims and the priorities. The operational plan with key performance indicators identified went to the April 2018 board meeting for approval. Whilst this had indicators identified there were no milestones identified to ensure that the implementation of the plan was on track.

The trust had a nursing and midwifery strategy which was based around the ‘6Cs’ of care, compassion, competence, communication, courage and commitment.

There was no strategy for mental health and learning disability patients in the trust though we were told this was being developed. Also in development was a revised workforce strategy. There was a dementia strategy in place which outlined how it was going to achieve its aims, for example undertake regular audits to seek carer’s views and implement a training programme. However, there were no milestones or timeframes identified and the strategy had no date for the time period it related to.

The trust had a hospital pharmacy transformation plan supported by a medicines optimisation strategy and delivery plan 2015-2020. There was a comprehensive workforce strategy for pharmacy looking at developing enhanced roles to support divisions. For example, pharmacist non-medical prescribers and consultant pharmacists working in specialist areas of cardiology and intensive care; and a successful pilot of technician led medicines administration which was being considered for expansion. Although pharmacy staffing was at establishment, there was evidence of overtime and plans were in place to fund additional extended roles within the trust to support delivery of seven day working.

**Culture**

The trust had a policy in place relating to the duty of candour requirements. This was overdue for review at the time of the inspection. This outlined the process that verbal notification and an apology, that a moderate or above suspected patient safety incident has occurred, must be made to the patient or their family/carer within 10 working days of the incident being reported followed by a summary letter. However, the policy also stated that agreement had been made with the local commissioning group that the 10 working days would begin once the root cause analysis investigation process had been confirmed. This meant there was a risk that the trust would not be compliant with legislation as not all moderate or above incidents may result in a root cause analysis investigation or a delay due to the processes to agree that a more in-depth investigation was to be undertaken.

The moderate and above incidents we reviewed between September April 2017 to 6 March 2018 showed in 14% (9 out of 66) of the incidents duty of candour had not been applied.

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.

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 safely. The role of the freedom to speak up guardian had been created as a result of recommendations from Sir Robert Francis in February 2015. The trust had one in place; however, this was a recent appointment and was on a secondment basis. There were freedom to speak up champions in services. There was also a dedicated phone line available for staff to use 24 hours a day seven days a week.

There were examples where issues had been raised with the freedom to speak up guardian and champions but divisional managers had not responded in a timely way. However, when raised with executives following the departure of the previous chief executive the issues were looked into. Staff were reporting that there had been an improvement in being able to approach the executive team with issues raised with them. Just before the well led inspection a decision had been made for the freedom to speak up guardian to report directly to the chief executive.

There a significant number of contacts from staff before and during the inspection informing us that they had concerns regarding the culture at the trust. Staff satisfaction across the trust was mixed. Staff did not always feel actively engaged, valued or empowered. We found there were teams working in silos and management and clinicians did not always work cohesively. For example the senior leadership team wanted to engage with the hospital medical board but had not been invited to their meetings despite requesting. Senior leaders recognised there was work to be done to improve the culture together with equality and diversity.

However, there had been improvements in the culture in maternity services since the last inspection. There were now regular staff meetings and staff reported that they saw their line manager regularly and there was good team working.

The pharmacy business plan was embedded into the pharmacy appraisal system and was distilled into the staff objectives ensuring the team were working to a common goal. Pharmacy Staff spoke to felt valued and able to make a difference. The 2017 staff survey was completed by 61% of the pharmacy team. 100% of staff felt able to contribute towards improvement at work and that their role made a difference.

Each site had a whole pharmacy team meeting each week ensuring good communication. There were several team initiatives including, save of the week, idea of the month and employee of the month. The variety and level of services being offered by the pharmacy team creates high expectations for the service delivered, there was a robust induction programme for staff members who told us they felt supported.

**Staff Diversity**

The trust provided information on their staff diversity as from March 2017 below:

<table>
<thead>
<tr>
<th>Pay Band</th>
<th>BME  (n)</th>
<th>Non-BME (n)</th>
<th>Ethnicity Unknown</th>
<th>Total Staff</th>
<th>BME %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Clinical Staff</td>
<td>23</td>
<td>1,818</td>
<td>34</td>
<td>1,875</td>
<td>1.2%</td>
</tr>
<tr>
<td>Clinical Staff</td>
<td>213</td>
<td>3,349</td>
<td>55</td>
<td>3,617</td>
<td>5.9%</td>
</tr>
<tr>
<td>Medical Staff</td>
<td>170</td>
<td>360</td>
<td>16</td>
<td>546</td>
<td>31.1%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>5</td>
<td>20.0%</td>
</tr>
<tr>
<td><strong>Trust Total</strong></td>
<td><strong>407</strong></td>
<td><strong>5,531</strong></td>
<td><strong>105</strong></td>
<td><strong>6,043</strong></td>
<td><strong>6.7%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity (WRES Report))
NHS Staff Survey 2017 – results better than average of acute trusts

The trust has seven key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF20. Percentage experiencing discrimination at work in last 12 months</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>KF29. Percentage reporting errors, near misses or incidents witnessed in last month</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>KF18. % attending work in last 3 months despite feeling unwell because they felt pressure</td>
<td>50%</td>
<td>52%</td>
</tr>
<tr>
<td>KF16. % working extra hours</td>
<td>70%</td>
<td>72%</td>
</tr>
<tr>
<td>KF23. % experiencing physical violence from staff in last 12 months</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>24%</td>
<td>28%</td>
</tr>
<tr>
<td>KF26. % experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>24%</td>
<td>25%</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2017 – results worse than average of acute trusts

The trust has 22 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. Percentage appraised in last 12 months</td>
<td>83%</td>
<td>86%</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>2.97</td>
<td>3.11</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.02</td>
<td>4.05</td>
</tr>
<tr>
<td>KF21. Percentage believing the organisation provides equal opportunities for career progression / promotion</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>KF28. Percentage witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>33%</td>
<td>31%</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.59</td>
<td>3.65</td>
</tr>
<tr>
<td>KF19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.52</td>
<td>3.62</td>
</tr>
<tr>
<td>KF15. Percentage satisfied with the opportunities for flexible working patterns</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.66</td>
<td>3.75</td>
</tr>
<tr>
<td>KF7. Percentage able to contribute towards improvements at work</td>
<td>66%</td>
<td>70%</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.86</td>
<td>3.91</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.61</td>
<td>3.72</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.25</td>
<td>3.31</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.35</td>
<td>3.45</td>
</tr>
<tr>
<td>KF6. Percentage of staff reporting good communication between senior management and staff</td>
<td>29%</td>
<td>33%</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.67</td>
<td>3.74</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.82</td>
<td>3.91</td>
</tr>
<tr>
<td>KF3. Percentage agreeing that their role makes a difference to patients / service users</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>KF32. Effective use of the patient or service user feedback</td>
<td>3.6</td>
<td>3.71</td>
</tr>
<tr>
<td>KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>KF24. Percentage of staff or colleagues reporting most recent experience of violence</td>
<td>65%</td>
<td>66%</td>
</tr>
<tr>
<td>KF27. Percentage of staff or colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>37%</td>
<td>45%</td>
</tr>
</tbody>
</table>

For three of the areas in the survey the trust’s performance was similar to the national average.

The overall engagement score for the trust (3.75) was below the national average of 3.79 and the response rate of 31% was amongst the worse 20% of all trusts.

The trust score was in the worst 20% of trusts for the question KF7 “Staff ability to contribute towards improvements at work (the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)”

Trust scores were worse than average or in the worst 20% of all trusts for the majority of questions relating to:

- Appraisal and support for development – Trust scores were worse than average for two, and in the worst 20% of all trusts, for one of the three questions.
- Job satisfaction – Trust scores were average for one, worse than average for three and in the bottom 20% of all trusts for two of the six questions.
- Managers – Trust scores were worse than average for two and in the worst 20% of all trusts for one of the three questions.
- Patient care & experience – Trust scores were in the worst 20% of all trusts for all three questions.

Trust score showed a mixed performance for questions relating to:

- Equality and diversity – Trust scores were worse for one and in the top 20% of all trusts for one of the two questions.
- Errors and incidents – Trust scores were worse than average for one, in the worst 20% of all trusts for one, better than average for one, and average for one of the four questions.
- Health and wellbeing – Trust scores were better than average for one, average for one and worse than average for one of the three questions.
- Violence, harassment and bullying – Trust scores were in the best 20% of all trusts for one, better than average for two, worse than average for two and in the worst 20% of all trusts for one of the six questions.
- Working patterns – Trust scores were better than average for one and worse than average for one of the two questions.

(Source: NHS Staff Survey 2017)
Workforce race equality standard 2017

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th>NHS Staff Survey Indicator</th>
<th>Proportion of respondents answering &quot;Yes&quot;</th>
<th>% difference between BME and white staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>Trust: 20.0% BME staff; 21.3% White staff</td>
<td>1.3%</td>
</tr>
<tr>
<td></td>
<td>England: 27.7% BME; 26.7% White</td>
<td>-1.6%</td>
</tr>
<tr>
<td>KF26. Percentage of staff experiencing harassment, bullying or abuse from staff the last 12 months</td>
<td>Trust: 25.0% BME staff; 22.6% White staff</td>
<td>-2.4%</td>
</tr>
<tr>
<td></td>
<td>England: 25.0% BME; 26.7% White</td>
<td>-1.6%</td>
</tr>
<tr>
<td>KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion</td>
<td>Trust: 75.0% BME staff; 84.0% White staff</td>
<td>9.0%</td>
</tr>
<tr>
<td></td>
<td>England: 71.6% BME; 87.1% White</td>
<td>15.5%</td>
</tr>
<tr>
<td>Q17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?</td>
<td>Trust: 10.0% BME staff; 6.6% White staff</td>
<td>-3.4%</td>
</tr>
<tr>
<td></td>
<td>England: 15.5% BME; 6.6% White</td>
<td>-8.9%</td>
</tr>
</tbody>
</table>

There were no questions where there was a statistically significant difference in score between White and BME staff.

(Source: NHS Staff Survey 2017)

As part of this inspection, we reviewed the trust’s implementation of the Workforce Race Equality Standard and its approach to equality and diversity. The Workforce Race Equality Standards is a mandatory requirement for NHS organisations to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve black and minority ethnic board representation.

The trust had a published document for Workforce Race Equality Standard for July 2017 with an action plan in place. The draft action plan we reviewed did not link to the trust’s equality objectives. The trust acknowledged that, in respect of ethnicity, the board was not representative of the population it served or its workforce. There was no specific action on the draft action plan to address this.

There were currently no equality and diversity groups or network within the trust. Staff told us this would be included in the equality and diversity strategy that was being developed.

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 slightly above the England average for recommending the trust as a place to receive care from December 2016 to October 2017. However, no data was submitted for the most recent month, November 2017.

(Source: Friends and Family Test)

**Sickness absence rates**

The trust’s sickness absence levels from December 2016 to November 2017 were consistently higher than the England average. The overall trend shows an increase in sickness rates.

(Source: NHS Digital)
General Medical Council – National Training Scheme Survey

In the National Training Scheme Survey by the General Medical Council the trust performed worse than expected for one area (induction) and the same as expected for the remaining 13 indicators.

(Source: General Medical Council National Training Scheme Survey)

The trust had an annual staff awards programme to recognise and reward staff.

The trust had recently introduced FabCan events. These are fabulous change agent network events where like-minded people come together to build a network to connect the trust strategy to staff in the organisation. These events also help organisations change in attitude, beliefs and behaviours. We saw evidence that there had been a number of events attended by staff including book clubs and coffee mornings. Twenty four pledges for change have been made with 17 completed.

Governance

The trust had a governance structure in place but these were not fully established and were fragmented in places. This meant there was limited oversight of risks and issues facing services within the organisation.

The trust structures included board committees, divisional committees and team meetings. However, during inspection we found some areas were not effective. For example, there were investigations that were overdue and overdue actions from these investigations which meant there was a risk that the board were not assured that all learning was being implemented in a timely way.

On reviewing recent board papers and committee papers they were of a relatively good standard and contained appropriate information. However not all actions identified in the minutes included a timeframe for completion or completed in a timely way. For example, the quality and safety committee. There were also actions that had been identified in November 2017 which had still not been completed in March 2018.

In May 2017 there was an external quality governance review undertaken. This resulted in a 58 recommendations. This was presented to the senior management team meeting and at the directors development workshop in July 2017. However, we saw no evidence that this had been presented to the board for approval of the recommendations. We saw evidence that some of the recommendations had been implemented for example the integrated quality governance dashboard. However, this was still in the early stages and whilst it identified performance data and also in some cases highlighted gaps not all were addressed by clear actions to improve the standards. The dashboard was presented to the clinical governance group. We reviewed the minutes of these meetings and found that the dashboard was discussed. It was also noted in these meetings that the dashboard needed to evolve over the coming months.

Whilst some recommendations from the quality governance review had been implemented it was unclear where the trust were up to in the implementation of all the recommendations. There was a quality governance roadmap that had been developed which was a plan of when the recommendations would be implemented. However, we saw no evidence that this was being monitored by the board or any of the committees of the board. This meant there was limited board
oversight into the changes being made to the structures and processes to ensure they were not impacting on service delivery and patient care.

Staff informed us that in the early stages of the implementation of the recommendations a number of committees had been abandoned and the new committee structure not fully implemented. We asked senior staff if this process had been risk assessed and actions put in place to mitigate any risks. We were told that no risk assessment had been undertaken. This had led to confusion on the roles of the committees for staff in services. There was also a risk that inconsistent information and scrutiny on quality and safety of services and missed opportunities for lessons to be learnt may occur. For example, the patient and family experience group had been disbanded early in the process and staff told us they were unclear where patient experience was being discussed and acted upon.

At the time of the inspection some senior managers told us that further implementation of the governance review recommendations had been put on hold as the new interim chair had a further external review of the governance processes and structure. Some senior managers informed us that the hold was for a review of the governance leadership only. Therefore, it was unclear if all senior managers were fully aware of the reasons for any of the governance processes put on hold.

The quality and safety committee had commissioned ‘deep dives’ into areas of risk. For example, nutrition and hydration. We reviewed the report and found that issues had been identified around patient menus available which were not in line with national guidance and the trust had been identified as a low performer in several external audits and also in internal key performance indicators. As a result the nutritional and hydration working group and steering panel and been re-established with revised terms of reference and membership. Staff informed us that these had been disbanded as part of the governance review early on in the implementation process.

The medicines safety and optimisation group and the Wirral Drug and Therapeutics Panel fed into the trust clinical governance group. The medicines safety and optimisation group had remained quorate all year.

We reviewed the trust’s policies and procedures. At the time of the inspection we found that 30% (10 out of 34) governance policies were past their review dates between two months and 11 months. Policies that were out of date included concerns and complaints handling and incident reporting. We also found that 20% (10 out of 49) of clinical practice policies were past their review dates between two months and nine months. Policies that were out of date included adult missing patient policy and procedure and the perioperative surgical site markings. This meant there was a risk that staff were not following up to date best practice guidance.

We reviewed the incident reporting policy and found that this was due for review in July 2017 and had not been updated to reflect the NHS serious incident framework 2015. The process of completing a 72 hour review which was good practice carried out by the trust was also not reflected in the policy. This meant there was a risk that staff may not be managing incidents in line with current best practice guidelines.

The sepsis team worked collaboratively with other organisations through the AQUA programme and there was a trust sepsis governance group that met quarterly. This had good representation from divisions and sepsis data was reported through this forum. the Advancing Quality Alliance
supports its members in the North West to deliver the best health, wellbeing and quality of care for patients.

**Management of risk, issues and performance**

There was a central safeguarding team who identified and co-ordinated the trust response to mental health capacity issues and deprivation of liberty safeguards. There was a pathway that had been developed that when a patient required a deprivation of liberty being put in place the central safeguarding team would make the application to the local authority. However, this automatically put in place a delay in application as the team did not operate 24 hours a day. On reviewing records we also found a delay in applications following a deprivation of liberty being put in place across a number of areas.

A deprivation of liberty means taking someone's freedom away. A recent Supreme Court judgement decided that someone is deprived of their liberty if they are both 'under continuous supervision and control and not free to leave'. This may occur when a person who has been assessed not to have capacity to consent to their care and treatment, is cared for in such a way that restricts it impacts on their freedom. This may be done following a decision which confirms the care provided is in the best interests of the patient and that actions taken are the least restrictive. This is then authorised if appropriate by the local authority.

We reviewed 18 records of patients who lacked capacity and had restrictions put in place.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Date of capacity assessment</th>
<th>Date of DoLs application</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>No evidence of capacity assessment</td>
<td>17.1.18</td>
</tr>
<tr>
<td>11</td>
<td>24.11.17</td>
<td>11.12.17</td>
</tr>
<tr>
<td>11</td>
<td>17.2.18</td>
<td>20.2.18</td>
</tr>
<tr>
<td>19</td>
<td>8.3.18</td>
<td>9.3.18</td>
</tr>
<tr>
<td>19</td>
<td>20.3.18 (after application)</td>
<td>19.3.18</td>
</tr>
<tr>
<td>23</td>
<td>16.3.18</td>
<td>20.3.18</td>
</tr>
<tr>
<td>23</td>
<td>5.3.18</td>
<td>8.3.18</td>
</tr>
<tr>
<td>27</td>
<td>19.1.18</td>
<td>9.2.18</td>
</tr>
<tr>
<td>27</td>
<td>9.3.18</td>
<td>15.3.18</td>
</tr>
<tr>
<td>27</td>
<td>14.3.18</td>
<td>15.3.18</td>
</tr>
<tr>
<td>27</td>
<td>20.3.18</td>
<td>20.3.18</td>
</tr>
<tr>
<td>27</td>
<td>3.3.18</td>
<td>13.3.18</td>
</tr>
<tr>
<td>24</td>
<td>21.1.18</td>
<td>26.2.18</td>
</tr>
<tr>
<td>24</td>
<td>21.1.18</td>
<td>22.2.18</td>
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<tr>
<td>22</td>
<td>19.3.18</td>
<td>19.3.18</td>
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<tr>
<td>22</td>
<td>26.2.18</td>
<td>20.3.18</td>
</tr>
<tr>
<td>22</td>
<td>28.2.18</td>
<td>20.3.18</td>
</tr>
<tr>
<td>10</td>
<td>7.3.18</td>
<td>21.3.18</td>
</tr>
</tbody>
</table>

14 records showed a delay between the mental capacity assessment being completed and a deprivation of liberty application being made. These ranged between one day to 22 days delay. Seven of these were over five days delay. Applications for deprivation of liberty safeguards should be submitted as soon as the lack of capacity is identified and the assessment completed. Of the 18 records reviewed two deprivation of liberty applications had been made but here was no
evidence of a capacity assessment being made. This meant that patients were potentially being unlawfully deprived of their liberty.

Since the inspection, the trust have informed us that a system has now been put in place that once a mental capacity assessment has been completed on the electronic system, a deprivation of liberty application form is completed and automatically sent to the local authority direct rather than going through the safeguarding team.

At the last inspection, the trust were issued a requirement notice as the safeguarding children’s training did not meet the safeguarding children and young people: roles and competences for health care staff intercollegiate guidance March 2014.

At this inspection, safeguarding adult and safeguarding children’s training was done in one day (eight hours). The intercollegiate document states that level 3 training needs to include refresher training over the three year period at a minimum of two hours per annum and a minimum of six hours for those requiring more specialised training. We saw no evidence of annual updates nor were staff responsible for safeguarding aware of annual updates.

The trust had in place up to date and appropriate safeguarding policies for adults and children and there was a trust safeguarding executive lead. There was also an up to date mental capacity act 2005 policy. The trust had also developed the role of paediatric safeguarding ambassadors who were the point of contact in services. There was also a policy in place for VIP and celebrity visits to help ensure the safety of patients. The trust had a number of volunteers in place who had all been checked via the disclosure barring service.

There was a newly established safeguarding committee which planned to meet every two months where performance data was to be discussed. This was going to be chaired by the director of nursing. However, the terms of reference were still in draft format and of note the head of safeguarding was not a member of the committee.

We reviewed the safeguarding strategic team minutes between October 2017 to January 2018. We found no evidence of representation from the trust executive lead for safeguarding or representations from other clinical services. However, there was a note in January 2018 minutes that divisions would be attending in the future.

The trust had access to child and adolescent mental health services Monday to Friday 9am to 5 pm but there was no provision available to support children out of hours. We checked four case notes in children’s services and found that three out of four records did not record that safeguarding concerns had not been assessed or questions asked. Staff told us that this was not a mandatory field to complete.

Senior staff informed us that they did not collect the acuity and dependency of patient data at ward level. There were daily meetings to discuss staffing within the divisions on a regular basis but no overall view of what the staffing in the trust looked like as a whole on a daily basis only the exceptions. This meant there was limited oversight of all staffing levels across the services.

There was a risk management strategy 2016 to 2019 in place. This outlined the aims, accountabilities, responsibilities and organisation framework for the management of risk across the organisation. It identified the risk management escalation processes and guidance on scoring risks using a matrix system. This meant that the trust provided guidance to staff to ensure risks were being mitigated.
Senior leaders met with the divisions on a quarterly basis to review performance. This looked at risk and performance issues and agreed actions to improve performance. However, the last performance reviews took place in October 2017 and were not due to be held again until June 2018. Staff told us that this was due to the recent changes to the leadership team.

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£306.1m</td>
<td>£321.5m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£15.4m)</td>
<td>(£11.9m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£321.5m</td>
<td>£333.4m</td>
</tr>
<tr>
<td>Budget (Surplus or budget deficit)</td>
<td>Not provided</td>
<td>Not provided</td>
</tr>
</tbody>
</table>

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

The chair of the audit committee was clear on their responsibilities and told us they received assurance that the other board sub committees were working effectively through annual reviews.

The chief operating officer and chair of the audit committee both had a good understanding of the financial position of the trust. The chief operating officer understood their role in developing and delivering cost improvement programmes while maintaining quality.

The trust has recently implemented a new divisional management structure to support greater clinical accountability of the trust financial position. At the time of the inspection the structure had not been in place long enough to review the effectiveness in relation to this function.

Financial training was available to staff, but it was recognised that further development was required for clinical staff. A refreshed approach was to be included in the new leadership development programme. Board papers contained detailed explanation of the trust’s financial position, and indicated risks as well as mitigations. Senior leaders told us that the financial position and risks were discussed at board meetings and sub committee meetings and they had a shared understanding for the reasons for the under performance between April 2017 and March 2018.
Trust corporate risk register

The trust provided a document detailing their 29 highest profile risks. Due to the large number of risks, only those with scores of 16 to 20 have been presented. Twenty is the upper limit for risk scores.

<table>
<thead>
<tr>
<th>ID</th>
<th>Date risk opened</th>
<th>Title</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Last review date</th>
</tr>
</thead>
</table>
| 3076| 22/05/17         | Increasing demand and the ability to move patients onwards on an appropriate pathway. | **Impact:**
Failure to meet ED standards
Long waiting times
Reduction in staff morale
Increased staff sickness/absence
Additional Escalation areas set up
Increased ambulance handover times
Increase in incident reporting for patient care

**Consequence:**
Inability to deliver care within four hours
Poor patient experience
Loss of STF
Reputation of trust damaged.                                                                 | 20                   | 10/07/2017         |
| 3125| 16/10/17         | There is a risk to safety for patients with Head and Neck cancer requiring Speech and Language Therapy due to lack of suitably trained staff to deliver the service. | The Cancer Head and Neck service requires a highly specialist Speech and Language Therapist (SLT) to assess and treat patients referred for swallowing difficulties and voice problems following surgery or radiotherapy.

The service was delivered by 0.4 WTE Band 7 Locum Speech and Language Therapist who has ended her assignment in WUTH at short notice leaving the trust with no-one with the skills and knowledge to deliver care to these vulnerable patients. There is no-one to undertake video fluoroscopy, a real time x-ray examination of a person's ability to swallow safely and no SLT available to support the head and Neck cancer MDT.

The demand on the service is approximately 35 patients per | 20                   | 22/11/2017         |
week for outpatients plus a weekly telephone advice / follow up line provided by the SLT plus 10 patients per month for video fluoroscopy. There are also 26 laryngectomy patients on the outpatient caseload. None of the outpatient workload is currently covered and it is acknowledged that the caseload for Head and Neck patients is complex and patients are extremely vulnerable.

On average previously there were three new referrals weekly for inpatients, however, since the outpatient service is not available the service has seen an increase of patients being admitted to an average of 10 new patients per week. This may be as a consequence of the inpatient service not being available. Ward SLT are covering the inpatients referred with Head and Neck problems but the input is limited and the patients are receiving suboptimal care without a highly specialist SLT in the field of head and neck.

There is a national shortage of Cancer Head and Neck SLT and there is only one potential locum available who is only wishing to commit if she is employed for 0.8 WTE.

**Impact:**
Current number (August 17) is 64 WTE vacancies within the division. Constant challenge to ensure safe staffing levels across the Division
Multiple staff moves
Increased use of bank and agency staff
Negative impact on communication and continuity on clinical area

**Consequence:**
<table>
<thead>
<tr>
<th>Red</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2928</td>
<td>16/05/16</td>
<td>The Trust is illegally depriving patients of their liberty when urgent/extended</td>
</tr>
<tr>
<td>2772</td>
<td>03/07/15</td>
<td>Failure to comply with the Care Quality Commission's Fundamental Standards of Safety and Quality</td>
</tr>
<tr>
<td>2928</td>
<td>16/05/16</td>
<td>Failure to comply with the Care Quality Commission's Fundamental Standards of Safety and Quality</td>
</tr>
</tbody>
</table>

**Impact:**
A breach of the Deprivation of liberty Safeguards (2007) (Mental Capacity Act 2005) and breech or article 5 - Right to liberty (The Human Rights Act 1998) and The Care Act
<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>ID</th>
<th>Authorisations expire due to failure/delay of the external partner to carry out Best Interest Assessments to determine if DOLS is appropriate or not.</th>
<th>(2014) <strong>Consequence:</strong> This could lead to enforcement action by the CQC and possible reputational damage and litigation.</th>
</tr>
</thead>
</table>
| 2952| 08/07/16 | 2966 | 1) Patients and families do not perceive that care in that last days of life is patient/family focused  
2) Complaints were not always responded to promptly and no evidence of actions taken in response se to failures  
3) Delays in packages of care resulting in patients not being in preferred place of care and no audit/flagging system in place.  
4) Process not consistently in place to support advance care | There is a risk that the service is currently not configured or delivered in a way that ensure patients in the last year of life are recognised and plans of care discussed with them which will result in them receiving care in accordance with the five priorities of care. If this occurs this may result in: poor patient outcome, complaints, failure to deliver the national CQuIN, reputational damage. |
|     |        |      | 1) CQC judged that the trust did not collect and analyse all available information in medical care to support improvements in clinical and operational practice. | There is a risk that the trust will continue to be non-compliant with the findings of the CQC inspection in September 2015 and the requirements of the HSCA Regulation 17 (Good Governance) in relation to the collection and analysis of information to improve clinical and operational practice in medical care. If this occurs this may result in: |

**20171116 900885 Post-inspection Evidence appendix template v3**
<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/07/16</td>
<td>CQC reviewed a sample of 23 patient records in the emergency department and found that 19 were not fully completed. For example, pain scores were missing in six records, initial observations were missing in three records and information relating to safeguarding and social circumstances was not recorded in five records.</td>
<td>There is a risk that the trust will continue to be non-compliant with the findings of the CQC inspection in September 2015 and the requirements of the HSCA Regulation 17 (Good Governance) with regard to record keeping in the emergency department. If this occurs this may result in: patient safety risks, increased complaints, enforcement action by the CQC, litigation, press interest, reputational issues, and financial issues.</td>
</tr>
<tr>
<td>08/07/16</td>
<td>CQC were concerned that records were not always secure, accurate or completed fully. This is because record trolleys were left unlocked on some of the medical wards which they visited.</td>
<td>There is a risk that the trust will continue to be non-compliant with the findings of the CQC inspection in September 2015 and the requirements of the HSCA Regulation 17 (Good Governance) regarding the storage of case notes and records. If this occurs this may result in: patient safety risks, increased complaints, enforcement action by the CQC, litigation, press interest, reputational issues, and financial issues.</td>
</tr>
<tr>
<td>08/07/16</td>
<td>There was insufficient implementation of changes in best practice guidance from lessons learnt from incidents or root cause analysis.</td>
<td>There is a risk that the trust will continue to be non-compliant with the findings of the CQC inspection in September 2015 and the requirements of the HSCA Regulation 17 (Good Governance) in relation to learning from incidents and investigations in the maternity service and the facilitation of</td>
</tr>
<tr>
<td>Date</td>
<td>14/07/2017</td>
<td>Changes to practice and service improvements. If this occurs this may result in: patient safety risks, increased complaints, enforcement action by the CQC, litigation, press interest, reputational issues, financial issues</td>
</tr>
<tr>
<td>-------</td>
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<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2971</td>
<td>08/07/16</td>
<td>CQC were concerned that the systems to determine staffing levels in children's and young people's services were not robust. There is a risk that in line with the findings of the CQC inspection in September 2015 and the requirements of the HSCA Regulation 18 (Staffing) staffing levels in the trust be inadequate to meet the care needs of patients. This is with regard to the systems to ensure adequate and appropriate staffing levels in maternity, children’s and young people’s services If this occurs this may result in: risks to patient safety, poor patient and carer experience, increased complaints, enforcement action by the CQC, press interest, reputational issues, financial issues</td>
</tr>
<tr>
<td>2973</td>
<td>08/07/16</td>
<td>CQC found that there was an insufficient number of staff in theatre recovery with training in paediatric life support despite regularly caring for children. There is a risk that: in line with the findings of the CQC inspection in September 2015 and the requirements of the HSCA Regulation 18 (Staffing) staffing levels in the trust be inadequate to meet the care needs of patients. This is with regard to the insufficient number of trained staff in theatre recovery with training in paediatric life support If this occurs this may result in: risks to patient safety, poor patient and carer experience, increased complaints, enforcement action by the CQC, press interest, reputational issues, financial issues</td>
</tr>
<tr>
<td>3058</td>
<td>04/05/17</td>
<td>Sustained and increased demand for <strong>Impact:</strong> Delays in handover of care from ambulance crews to ED</td>
</tr>
</tbody>
</table>
Emergency Department services.

Staff are detrimental to clinical quality and patient experience. Turnaround delays can have an impact on overall response times as ambulances are held back from taking on their next 999 call.

Increased triage time (recommend 15-30 minutes) more often in the afternoon two hours due to lack of capacity. Waiting room can have majors patients in it as they have walked in with chest pain.

Lack of facilities within trolleys for bedded down patients. Not enough physical beds, leading to discomfort and poor pressure area care. No tables so that patients requiring breakfast have nowhere to eat off. No adequate catering facilities (hot meals) therefore patients over 12 hours offered sandwiches twice.

No showering or washing facilities for patients bedded down overnight. Delayed medications due to stock availability for regular medications.

General poor experience as unable to turn lights down and convert to ward based environment and also mixed sex bays.

Inability to adequately clean and stock each area between patients leading to risks.

**Consequence:**
Patient experience is not optimal:
Due to constant overcrowding ED staff sickness may increase, increase turnover of staff, burnout/ fatigue and potential clinical error.
Due to constant overcrowding ED staff sickness may increase, increase turnover of staff, burnout/ fatigue and potential clinical error
Increased minors breaches as capacity is full.
<table>
<thead>
<tr>
<th>Table Row</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3094</td>
<td>21/06/17</td>
<td>The trust may be unlawfully detaining patients due to Mental Capacity Assessments not being completed in a timely fashion; therefore applications for Deprivation of Liberty cannot be completed by the Safeguarding Team. <strong>Impact:</strong> A breach of the Deprivation of liberty Safeguards (2007) (Mental Capacity Act 2005) and breach or article 5 - Right to liberty (The Human Rights Act 1998) and The Care Act (2014) <strong>Consequence:</strong> This could lead to enforcement action by the CQC and possible reputational damage and litigation.</td>
</tr>
<tr>
<td>3100</td>
<td>20/07/17</td>
<td>The trust has a CIP requirement for each division and speciality area. <strong>Impact:</strong> Directorate unable to meet CIP target. <strong>Consequence:</strong> Failure to achieve CIP target.</td>
</tr>
<tr>
<td>3101</td>
<td>20/07/17</td>
<td>The trust has a CIP requirement for each division and speciality area. <strong>Impact:</strong> Directorate unable to meet CIP target. <strong>Consequence:</strong> Failure to achieve CIP target.</td>
</tr>
<tr>
<td>3102</td>
<td>20/07/17</td>
<td>The trust has a CIP requirement for each division and speciality area. <strong>Impact:</strong> Directorate unable to meet CIP target. <strong>Consequence:</strong> Failure to achieve CIP target.</td>
</tr>
<tr>
<td>3121</td>
<td>12/10/17</td>
<td>There is a risk that urgent blood tests for A/E will be delayed when the pneumatic tube system is out of action. When the pod system is down, samples have to be transported to the lab manually and require staff time. The pneumatic air tube system connects the ED, ward locations and Women's and Children's with the laboratory. The current system is 12 years old, unsupported by a maintenance contact and fails regularly (at least once per month). Over a 12 month period last year the current service provider has attended site on 15 separate occasions and a total of £8,962.48 has been spent on attendances and repairs. It is regularly failing again this year. The pods associated with the...</td>
</tr>
</tbody>
</table>
current system are of poor quality and break regularly. Rivets shear off. Of 50 pods purchased 6 months ago 30 are now U/S and are damaging the tubes

Last year over 30 patient samples including urgent transfusion specimens were stuck in the system for 3 days until they were removed by the current provider. The samples had to be retaken and were useless. Patient diagnosis/treatment was delayed.

(Source: Trust Corporate Risk Register / Board assurance framework)

During the inspection we were provided with an updated risk register which showed that the risks on the corporate risk register had been reviewed in March 2018. However, we asked for evidence that the risks had been reviewed between the risk register provided before the inspection and the review in March 2018. The trust did not provide us with any evidence. Therefore, we were not assured that all risks were being reviewed in a timely manner.

There had been a recent external review of the electronic system to record risks and incidents had been undertaken but there were still issues outstanding. For example, staff could look at the risk register on the electronic system but could not pull off a report. Staff informed us that risk assessments from services were sent to the department and then uploaded onto the electronic system. The information was then put into a spreadsheet to produce a report to committees. This meant there was a risk that important information on risks may not be up to date or correct.

On reviewing the corporate risk register further development was required to refine it into a document that reflects the real corporate risks. For example, the highest risk was staffing in medical care services but there was no articulation that it was an organisational wide risk even though we found staffing issues in other services during our inspection of core services. Also, the financial challenges for the trust were not identified on the corporate risk register.

On reviewing the divisional risk registers there were a number of risks that had been on the risk register for a number of years, not been reviewed in a timely way and there was no record that some actions had been completed.

Pharmacy risks were being managed effectively. Missed medication doses were included as a risk on the risk register and actions had been put in place to mitigate the risk. Although the last audit showed slight deterioration in inappropriately missed critical medicines (2.3% up from 1.7%) between quarter October 2017 and March 2018 the overall improvement during between April 2017 and March 2018 was significant. Work was ongoing to link the electronic system for improvements.
Board assurance Framework

The trust provided their Board Assurance Framework, which details eight strategic objectives and the accompanying risks. A summary of these is below:

- To deliver consistently high quality secondary care services enhanced through the provision of regional specialist services within available resources
- To ensure our people are aligned with our vision
- We make the best use of the public resources we have to deliver high quality, locally accessible services that are clinically and financially sustainable
- We consistently deliver safe, high quality, locally accessible services with health outcomes that compare with the best
- We provide safe, high quality, locally accessible services in partnership with primary, social and community care, now and in the future
- We put our people first so they can put our patients first, and we create the workforce of tomorrow by investing in the workforce of today
- We excel in a quality improvement/learning culture that allows us all to reduce unwarranted variation and constantly improve our services
- We are a national exemplar for transforming care through innovation and technology

(Source: Trust Board Assurance Framework)

The board assurance framework is a high level document that records the key risks that could impact on the trust achieving its strategic objectives. This included the impact and consequences together with the gaps in assurances. Actions had been identified for the gaps. At the time of our inspection, we found there were executive leads identified for each of the risks.

The board assurance framework and associated risk scores went to the trust board meeting in March 2018. These had now been aligned to the corporate risk register. On reviewing the board assurance framework there were still a large number of risks and the risk appetite was not clear. There was no clear ownership of the document and staff told us that since the director of corporate affairs had been off work ‘everyone owned it’.

On reviewing the minutes of the March 2018 board meeting we found that the board assurance framework was discussed and it was agreed that a further refresh and review was agreed as a way forward. It was also agreed that divisional leadership would be engaged.

The trust was working with external stakeholders to improve the performance of the trust in relation to access and flow of patients through the hospital but this remained a challenge for the trust which had high occupancy levels across all areas. Insufficient beds to meet the demand from the accident and emergency department was on the risk register with actions identified to help improve flow through the hospital. However, during the inspection we observed a number of escalation areas being opened and there was no evidence of a risk assessment being completed to ensure all the correct equipment and staffing was in place to maintain a safe environment for the patient. We observed areas being used that was inappropriate for patients to be cared for overnight. For example, the recovery area, the day case unit and the ambulatory care unit.

There were a high number of patient moves during their stay which were not always part of the care pathway. A high number were after 10 p.m. at night and staff told us this was due to the demand for beds on speciality wards and at time moves to escalation areas that had been
opened. Between 1 December 2016 and 30 November 2017 there had been a total of 12,098 patient moves at night, excluding transfers from the emergency department. The number of patient moves at night did not appear on the performance dashboard or the corporate risk register. This meant we not assured that these were being monitored effectively to reduce the number of patient moves.

At the time of the inspection there were 100 patients who were fit for discharge but were still in a hospital bed waiting for discharge. This was due to a number of reasons, for example waiting for care packages or a place in a nursing home. Between 1 December 2016 and 30 November 2017, the number of delayed discharges across the trust were 3332. The trust were currently looking into solutions which included how they could use the clatterbridge site more effectively to help release the number of beds available for acutely ill patients.

**Information management**

We were provided with a variety of data before the inspection but found that this was difficult to analyse due to the way it had been presented. This was particularly so for the mandatory training, sickness, staffing establishments and vacancy rates. This was raised with the trust before the inspection who recognised that the data may not be correct. We requested mandatory training information again during the inspection which showed an improvement in compliance. However, during the well led inspection a number of senior managers informed us that they were not confident that this data was correct and the compliance level may be lower. Therefore, we were not assured that the board had the correct data to provide assurances. An external audit organisation was going to commissioned to complete an audit on all workforce key performance indicators.

We were informed that the board were confident that financial and operational performance data was accurate

Senior managers and staff within corporate services told us that there was also issues with data around complaints and incidents on the electronic system and staff were not always able to gather reports from the system to inform performance and any learning.

RIDDOR incidents were reported to two different committees, safety incidents that occurred outside of the ward area were reported to the health and safety committee and those that occurred inside the ward area the quality and safety committee. Staff informed us that they had been unable to get a report from the electronic incident system for the past six months to get a full oversight of all RIDDOR reportable incidents and this had led to the health and safety committee not being aware that an incident had occurred that should have been reported in line with the reporting of injuries, disease and dangerous occurrences regulations 2013.

When incidents were reported on the system these were scored by the member of staff reporting the incident. The system would then allocate the incident to the line manager to review and identify any action required. We were told by a number of staff that a number of these incidents were in the ‘web-holding’ part of the system. This was where the incident had been allocated to the line manager but no action or review had been taken. This mean that there was a risk that potential learning from incidents may be missed or not acted on in a timely way to mitigate the risk of the incident happening again.
Staff had access to summary care records and this was appropriately managed. They had access to IT equipment and systems on all the wards and departments. The trust was working towards a full electronic patient record.

The trust reported that they were not meeting the accessible information standard. A risk assessment had been completed for none compliance and an action plan put in place. One of the actions was to develop an accessible information standard. However, we were informed by the trust that a draft policy was developed in 2016 but this had not progressed through the governance structures.

The trust had a sepsis pathway in place which was paper based. This had gone live in October 2017 and was due to be launched trust-wide electronically but was currently on hold whilst the electronic system was still being built. Staff told us that this meant data was difficult understand and was not always as useful as it could be to inform performance.

The trust had in place a Caldecott guardian and an senior information risk officer. The senior information risk owner was accountable and responsible for information risk across the organisation.

ePMA was widely used at the trust however there are still elements of paper charts being used for prescribing. The paper charts were to be replaced over time in line with the Global Digital Excellence plan. The pharmacy informatics team had recently appointed two new members and were now able to be more responsive to need. The new roles were split so the team were ward based and had real time operational awareness of the prescribing system and were working towards the Global Digital Excellence plan. The pharmacy team were liaising with other hospitals to support development of the IT system.

Engagement

The trust was building partnerships with other trusts in recognition for the need to work in a more integrated way across provider and partner organisations for the benefit of patients. The trust had established an acute care alliance with a neighbouring hospital to explore clinical and corporate collaboration opportunities.

The CCG had formed a Wirral Integrated Provider Partnership with all providers on the Wirral including the Local authority & GP federations as part of the Healthy Wirral Programme and were working with time on a new model of care for the over 50 years of age population. The trust were part of this programme.

Communication systems such as the intranet, newsletters and bulletins were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

The trust held listening into action events for staff to feedback on issues or concerns they had about a particular area and to get involved in change and improvements. Examples included supporting staff affected by cancer, radiology engaging staff in learning from incidents and the safe administration of medicines.
Patients and their relatives/carers were invited to attend the board meetings to share their story of the care provided at the hospital. This offered the opportunity for the trust to learn from best practice and what could be done better to improve care.

There was no evidence of the trust undertaking any public consultation in the last 12 months. Staff told us this was due to no significant changes that required external consultation.

The trust had a council of governors. They reported that they did not always feel engaged with the directors in regard to feedback from meetings and had not been aware of the initial findings from the core service inspections although they were aware this had been discussed in meetings. They did not feel they had been able to contribute to the effectiveness of the board. They felt their role was unclear and they were not valued. The role of council of governors is to ensure that the key stakeholders – patients, members of the public, staff and partner organisations – have a say in shaping their local health service.

The director of pharmacy and medicines management chairs the North West chief pharmacist group. The trust had established links with local pharmacy teams including continuing professional development sessions which provided joint opportunities.

**Learning, continuous improvement and innovation**

**Complaints process overview**

The trust concerns and complaints handling policy was not in date at the time of the inspection. It was due for review. This outlined the processes for dealing with a concern or complaint and the assessment of grading complaints. Different gradings were allocated different response timeframes depending on complexity. The policy also outlined that actions arising from formal complaint investigations an action plan should be put in place.

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

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3 working days</td>
<td>84%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>25 (level 2) / 45 (level 3) working days</td>
<td>17%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>60 (level 4) working days</td>
<td>38%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>1,124</td>
<td>last 12 months (Dec 2016 - Nov 2017)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview)
Number of complaints made to the trust

The trust received 340 complaints from December 2016 to November 2017. The surgery and medical care core services received the most complaints with 90 each.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>90</td>
<td>26.5%</td>
</tr>
<tr>
<td>Medical care</td>
<td>90</td>
<td>26.5%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>50</td>
<td>14.7%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>40</td>
<td>11.8%</td>
</tr>
<tr>
<td>Other</td>
<td>22</td>
<td>6.5%</td>
</tr>
<tr>
<td>Maternity</td>
<td>17</td>
<td>5.0%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>12</td>
<td>3.5%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>11</td>
<td>3.2%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>7</td>
<td>2.1%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>340</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

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

At the time of the inspection there were 148 complaints waiting to be investigated and 92 of these were overdue for responses in the timeframe agreed.

We reviewed five recent complaint files to see if these had been responded to within the timeframe outlined in the acknowledgment letter to the complainant. Only two of these had been responded to within the timeframe agreed. We reviewed a further 10 complaint files to look at the quality of the responses. We found that nine had an acknowledgement letter send to the complainant with the scope of the complaint investigation outlined. The investigation involved the relevant persons and responses were thorough. Apologies were outlined in the response letters were appropriate. There was no evidence of any risk assessments completed or use of a checklist to document the handling of the complaint which would have been good practice.

We were told that divisions were responsible for implementing any actions following learning from complaint investigations but we did not see any evidence of any action plans in the complaint files we reviewed.

Number of complaints outstanding were included in the integrated quality dashboard that was discussed at the clinical governance group. We reviewed the minutes of the meeting for March 2018 and found that the number of complaints and those which have breached policy timeframe was discussed and a tracker would be reinstated to highlight where the trust was breaching standards. The person responsible for the action was identified but no timeframe for the action to be completed. On reviewing the minutes of the April 2018 meeting we found that the action log from the previous meeting was deferred and not gone through to see if actions had been
completed. This meant we were not assured that actions identified to improve the complaint response timeframes were being actioned in a timely way.

The complaints team told us that they had not received any formal training in handling complaints. The complaints manager was due to leave at the end of May 2018 and there was no clear plan for recruitment into this position.

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.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy - January 2017</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189*</td>
<td>ISO15189 accreditation in Cellular Pathology, Microbiology, Biochemistry and Haematology</td>
</tr>
</tbody>
</table>

*The trust noted that, due to the unexpected and sudden loss of their quality manager, they had voluntarily suspended accreditation in microbiology for three months to enable them to prepare for the 2018 assessment as the trust would not have been ready to be reassessed in January 2018.

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

There was a weekly quality safety summit meeting which looked at themes from incidents and near misses. This was an open invite to any staff. We observed one of these meeting during the inspection and found that it was well attended. The purpose was to improve patient safety and to learn from incidents to prevent more serious harms happening to patients. Following this meeting a newsletter was circulated to staff to ensure learning was disseminated across the trust. We found that these were well attended and discussion about a number of incidents took place together with any initial learning.

Following this meeting a group of senior managers met to discuss serious incidents to decide which incidents were to be investigated doing a root cause analysis approach. At this meeting a decision was also made if the serious incident did not require any further investigation. On reviewing the notes of this meeting between 1 March 2018 and 19 April 2018 the rationale for the decision to either close the incident or not to investigate further was not recorded. This meant it was unclear if all potential serious incidents had been investigated appropriately to ensure any learning was identified to ensure patients were safe from avoidable harm. It was also unclear as to who had made the decisions as the attendance at the meetings was not always recorded.

We were told that this meeting was also used to track progress and quality of the root cause analysis reports but we saw no evidence of this on the notes we reviewed.

We reviewed the number of serious incidents that had been recorded between 1 December 2016 and 20 November 2017 and found that there had been a total of 120 recorded. The trust incident
reporting policy, which was out of date, stated that incidents must be reported within one day and the NHS Serious Incident Framework 2015 states that serious incidents must be reported within 48 hours. Out of the 120 serious incidents recorded only 22 had been reported in line with trust policy and 37 in line with the NHS Serious Incident Framework. There were a number which had taken a long time to report from when the incident had happened. For example, there was an incident which happened on 30 December 2016 which was not reported until 28 September 2017 and another incident happened on 23 December 2016 which was not reported until 3 March 2017. This meant there was a risk of missed opportunity for learning in a timely way to help prevent a further incident happening.

We reviewed six serious incident reports and found the investigator was independent to the incident. The reports identified a cause for the incident, the lessons that should be learnt from the incident, recommendations and an action plan.

Before the inspection we became aware of a serious incident where a patient came to serious harm following a fall from a defective bed. This had not been reported to the health and safety executive as outlined in national guidance. This was reported by the family in March 2018 after the incident occurred in August 2017. The trust had undertaken an initial 72 hour review with a recommendation that information on checking beds be put on the staff intranet and it was recorded that the incident did not need further investigation in August 2017. However, since the inspection the trust has informed us that there will be a full root cause analysis investigation completed.

There had been a recent serious case review which had a recommendation for the trust. This was to ensure children who attend the emergency department receive an effective treatment plan. The trust had put in place an action plan with a completion timeframe of April 2018. At the time of the inspection the actions identified were still to be fully completed and were due for review in June 2018.

The trust had in place a central alerting system officer and administrator who were responsible for patient safety alerts. These were disseminated across the trust but there had been no audit of compliance with the alerts. This meant we were not assured that staff were putting in place appropriate actions to learn from these alerts.

The national guidance on learning from deaths which was launched in March 2017 by NHS England expected each NHS trust to have published an updated policy by September 2017. A draft policy was in place but was still waiting to be approved at the time of inspection.

The trust was aiming for 100% of deaths to have primary mortality review. Following the review any further learning and a more detailed analysis would be undertaken through a structured judgement review where there was cause for concern. Between 1 April 2018 and 30 March 2018, it was reported that only 12% of all deaths had a primary mortality review which was below the present target of 50%.

Mortality reviews are undertaken to look at any learning that could be implemented to help minimise the risks of any future unavoidable deaths. Mortality reviews were discussed at the clinical governance group and the quality and safety committee meetings. The mortality dashboard goes to the board and the mortality review steering group.

Senior staff told us that reports were reviewed by physicians and radiologists but surgeons were reluctant to review reports for medical deaths but would carry out a structured judgement review for surgery deaths.

Following the mortality review the reports were sent out to the relevant division to be discussed. However, senior managers received no assurance that these had been discussed with staff. The
trust did not actively seek feedback from families and carers after each death unless a complaint was made about the care received.

Senior staff told us that some departments still had their own mortality meetings for example critical care. However, they feed into the main trust mortality review steering group. We reviewed the notes of the trust mortality review steering meeting which had only begun in May 2017 with the next one scheduled for August 2017. At the May 2017 meeting it stated that learning and dissemination was not discussed due to lack of time. On reviewing the minutes of the August 2017 meeting, January 2018 meeting and March 2018 meeting, there was no evidence that learning from deaths was discussed or on the agenda. This meant there was a potential for missed opportunities to learn from deaths.

The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. The current SHMI was 93 which is within the ‘as expected range’ for the trust. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. Risk is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to the England average. A score of more than 100 means more adverse (worse) outcomes than expected. The SHMI for the trust has showed a steady improvement during the last seven quarterly releases and is projected to remain in the ‘as expected range’.

The trust had a planned approach to take part in national audits and shared learning. Between April 2017 and March 2018 Forty six of these were relevant to the trust and they were participating in 39(84%). This participation was higher than this point in 2016/17. The trust participated in 100% of national confidential enquiries between April 2017 and March 2018.

We asked the trust for the compliance rate with relevant National Institute of Clinical Excellence guidance. These are to reduce variation in the availability and quality of treatment and care. The trust was unable to provide this information. A management of National Institute of Clinical Excellence work stream had just been set up on 1 May 2018. Actions had been identified which included looking at trust compliance with national guidance. At the time of the inspection there was no evidence that the trust had been monitoring compliance.

The trust held Schwartz rounds throughout the year. Schwartz rounds are an evidenced based forum for hospital staff to come together to talk about the emotional and social challenges of caring for patients. They offer support to one another.

The trust was part of the get it right first time programme. This programme was to help improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes

Although there was limited evidence of research being undertaken at the trust between April 2017 and March 2018 a total of 703 patients had been recruited to take part in research.

In November 2017 the trust had recently had an external quality review of education opportunities for university students at the trust. This had identified some good practice such as supportive, dedicated and approachable supervisors with a sense of pride and teamwork. However, there were a number of areas that required improvement. For example, the trust had been recommended to review its educational governance mechanisms for the quality control of placements and provide details on the metrics used to measure the quality of placements.
The trust was taking part in a global digital exemplar programme. This is a programme that has been developed by NHS England to encourage several trusts nationally to become exemplars in the use of digital systems and to help spread best practice and innovation to other providers.

The Finance department has achieved finance skills development level 1 and was currently working towards level 2.

The trust had four satellite dispensaries throughout the hospital, plus a mobile service. These strategically placed resources allowed increased responsiveness and held speed up the discharge process allowing specialist resources to be sited.

The trust was beginning to reimplement a ward accreditation scheme to help improve standards
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.

### Urgent and emergency care

#### Facts and data about this service

**Details of emergency departments and other urgent and emergency care services**

- Emergency Department, Arrowe Park.
- Emergency Department Review Unit, Arrowe Park.

(Source: Routine Provider Information Request (RPIR) P2 – Sites)

The emergency department provides care and treatment to approximately 250 adults and children a day. Services are provided to both adults and children for medical / surgical emergencies and trauma.

Some areas of the department had been redesigned. This included the reception area and waiting room, the triage and minor injuries area as well as the resuscitation and high dependency area. Other areas of the department, including the majors area, children’s area and the emergency department review unit are based in the old hospital.

The department has three rooms to manage mental health patients, including a 136 room for patients who were brought to the department by the police as a place of safety. Mental health liaison services are provided by a local mental health trust.
Activity and patient throughput

Total number of urgent and emergency care attendances at Wirral University Teaching Hospital NHS Foundation Trust compared to all acute trusts in England

There were 123,513 attendances from April 2016 to March 2017 at Wirral University Teaching Hospital NHS Foundation Trust as indicated in the chart above.  
(Source: NHS England)

Urgent and Emergency Care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission stayed the same from 2016/17 to 2017/18 and rates were higher than the England averages.  
(Source: NHS England)
Urgent and Emergency Care attendances by disposal method

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

We visited all areas of the emergency department including the reception and waiting area, the triage area, majors and resuscitation areas, the children’s area as well as the emergency department review unit.

We spoke to staff of different grades, including nurses, doctors as well as members of the management team from both the department and the division of medicine. We also spoke to staff from other areas of the hospital that had regular contact with the emergency department.

We reviewed 20 sets of patient records for adults and children, including five prescription charts. We also reviewed information that was provided by the trust before and after the inspection. We spoke to patients and relatives about their experience and observed care and treatment being delivered.
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 trust set a target of 95% for completion of mandatory training.

Block A contained manual handling, health and safety level 1, risk management level 1, consent awareness, end of life care and moving and handling modules. Block B contained fire safety, infection prevention and control and medicines management modules.

A breakdown of compliance for mandatory courses from April to October 2017 for nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block B</td>
<td>32</td>
<td>93</td>
<td>34%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>CPR</td>
<td>30</td>
<td>93</td>
<td>32%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>25</td>
<td>93</td>
<td>27%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block A</td>
<td>13</td>
<td>93</td>
<td>14%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security 1</td>
<td>10</td>
<td>93</td>
<td>11%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management Level 2</td>
<td>0</td>
<td>20</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by nursing staff in urgent and emergency care at the trust was 22.7%. This did not meet the trust target for any of the mandatory training modules.

A breakdown of compliance for mandatory courses from April to October 2017 for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td>8</td>
<td>32</td>
<td>25%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety Level 2</td>
<td>3</td>
<td>15</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block B</td>
<td>6</td>
<td>32</td>
<td>19%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block A</td>
<td>4</td>
<td>32</td>
<td>13%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management Level 2</td>
<td>2</td>
<td>18</td>
<td>11%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security 1</td>
<td>1</td>
<td>32</td>
<td>3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by medical staff in urgent and emergency care at the trust was 14.9%. Medical staff did not meet the trust target for any of the mandatory training modules.

(Source: Routine Provider Information Request (RPIR) P40 –Mandatory and Statutory Training)

We raised concerns with the management team during the inspection that records provided prior to the inspection showed that most staff had not completed mandatory training appropriately. As a result we were provided with the updated data to indicate that some improvements had been made for both nursing and medical staffing groups. However the overall compliance levels were still below the trust target and for some modules were particularly low.

A breakdown of compliance for mandatory courses in February 2018 for nursing staff in urgent and emergency care is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; Handling - People Handling</td>
<td>93</td>
<td>102</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling - Inanimate Loads</td>
<td>93</td>
<td>102</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management - Level 1</td>
<td>93</td>
<td>102</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Consent Part A</td>
<td>93</td>
<td>102</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety - Level 1</td>
<td>92</td>
<td>102</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>VTE Thromboembolism</td>
<td>90</td>
<td>101</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - Level 1</td>
<td>82</td>
<td>102</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - Level 1</td>
<td>82</td>
<td>102</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>76</td>
<td>96</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>CPR</td>
<td>80</td>
<td>102</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Protecting Vulnerable People - Level 3</td>
<td>77</td>
<td>102</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Deteriorating Patient</td>
<td>77</td>
<td>102</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>73</td>
<td>102</td>
<td>72%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - Level 2</td>
<td>70</td>
<td>102</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medical Devices</td>
<td>70</td>
<td>102</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - Level 2</td>
<td>69</td>
<td>102</td>
<td>68%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Transfusion Safety Training</td>
<td>58</td>
<td>96</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management - Level 2</td>
<td>9</td>
<td>21</td>
<td>43%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity - Level 1</td>
<td>34</td>
<td>102</td>
<td>33%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security Awareness - Level 1</td>
<td>34</td>
<td>102</td>
<td>33%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>19</td>
<td>102</td>
<td>19%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Administration of Blood Components</td>
<td>4</td>
<td>96</td>
<td>4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Collection of Blood Components</td>
<td>4</td>
<td>96</td>
<td>4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Labelling of Blood Components</td>
<td>4</td>
<td>96</td>
<td>4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

A breakdown of compliance for mandatory courses in February 2018 for medical staff in urgent and emergency care is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VTE Thromboembolism</td>
<td>26</td>
<td>28</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management - Level 1</td>
<td>27</td>
<td>31</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety - Level 1</td>
<td>27</td>
<td>31</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling - Inanimate Loads</td>
<td>27</td>
<td>31</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Protecting Vulnerable People - Level 3</td>
<td>13</td>
<td>15</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Protecting Vulnerable People - Level 2</td>
<td>13</td>
<td>16</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - Level 1</td>
<td>25</td>
<td>31</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - Level 1</td>
<td>25</td>
<td>31</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>24</td>
<td>31</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>CPR</td>
<td>24</td>
<td>31</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Deteriorating Patient</td>
<td>23</td>
<td>31</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Transfusion Safety Training</td>
<td>19</td>
<td>31</td>
<td>61%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medical Devices</td>
<td>17</td>
<td>31</td>
<td>55%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety - Level 2</td>
<td>15</td>
<td>30</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>15</td>
<td>30</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Consent Part A</td>
<td>15</td>
<td>31</td>
<td>48%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - Level 2</td>
<td>15</td>
<td>31</td>
<td>48%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - Level 2</td>
<td>15</td>
<td>31</td>
<td>48%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management - Level 2</td>
<td>8</td>
<td>17</td>
<td>47%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity - Level 1</td>
<td>7</td>
<td>31</td>
<td>23%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security Awareness - Level 1</td>
<td>5</td>
<td>31</td>
<td>16%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>5</td>
<td>31</td>
<td>16%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Labelling of Blood Components</td>
<td>1</td>
<td>30</td>
<td>3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Safeguarding**

The trust had policies for safeguarding adults and children which were available to all staff on the intranet. Staff that we spoke with knew how to access these if needed.

The trust had a designated safeguarding lead and there was a safeguarding team based in the hospital during normal working hours. Staff also had access to 24 hour external services if a safeguarding referral was required out of hours. Staff were aware of where to locate this information if needed.
A member of the trust-wide safeguarding team was based in the emergency department between Monday and Friday during normal working hours.

The trust used an electronic records system and an alert had been created to make staff aware of any safeguarding alerts. However, the trust did not have access to the child protection information sharing system. This was important as this system was used to share information about children who are looked after along with contact details for the appropriate social services team. We were informed that there were plans in place to introduce this in the next month.

All staff were required to complete training for safeguarding adults. In addition, all registered nurses, clinical support workers and medical staff were required to complete level 3 safeguarding training for children. This was in line with the intercollegiate document, 2014 (safeguarding children and young people) and was important as the department did not have a children’s nurse available out of hours.

Most staff that we spoke with were able to give us examples of what constituted as a safeguarding concern. Examples given included physical abuse, financial abuse and neglect. Staff also had an understanding of child sexual exploitation and Prevent (a government strategy to safeguard vulnerable individuals who are at risk of radicalisation). However, not all staff had an awareness of female genital mutilation. This was important as since October 2015 it is mandatory for regulated health and social care professionals to report all known cases of female genital mutilation in persons under the age of 18 to the police.

There were a number of screening questions to support staff in recognising safeguarding concerns for children. Examples of this included if there had been an inappropriate delay in presentation or if there were any inconsistent injuries.

We reviewed ten sets of records, finding that this system was used inconsistently. This was because the system used by children’s nurses when the children’s department was open was different to the system used by adult trained staff when the children’s department was closed. In addition, six of the records that we checked were for children who had attended out of hours. There was no documented evidence that the mandatory questions had been completed in three of these. This meant that there was an increased risk that safeguarding concerns would potentially be missed.

A member of the safeguarding team reviewed all records that were completed for children who attended the department, making sure that information was shared appropriately. However, they did not produce a report to indicate compliance with this.

We were informed that there had been a recent incident where the safeguarding team had reviewed a case retrospectively, finding that a child had attended the department and had been discharged inappropriately by staff. Staff had to request that the child re-attended the department and a safeguarding referral was subsequently made.

The safeguarding team held monthly meetings in the department. Minutes of these meetings indicated that safeguarding referrals were discussed as well as areas that required improvement. However, we noted that not all members of the management team from the department attended this meeting and safeguarding was not discussed at any other departmental meetings. This meant that we were unsure of how all safeguarding information was shared throughout the department.

Safeguarding training completion rates

The trust set a target of 95% for completion of protecting vulnerable people training.

The trust reported that their protecting vulnerable people courses contain safeguarding adults and children modules. Protecting vulnerable people courses contain modules relating to
safeguarding adults, safeguarding children, PREVENT, Mental Capacity Act, Deprivation of Liberty safeguards, domestic violence, Mental Health Act and dementia awareness.

The breakdown of protecting vulnerable people training completion from April to October 2017 for nursing staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting vulnerable people Level 2</td>
<td>46</td>
<td>92</td>
<td>42%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Protecting vulnerable people Level 3</td>
<td>42</td>
<td>92</td>
<td>39%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The breakdown of protecting vulnerable people training completion in February 2018 for nursing staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting vulnerable people Level 2</td>
<td>19</td>
<td>17</td>
<td>111.8%</td>
<td>95%</td>
<td>Not known</td>
</tr>
<tr>
<td>Protecting vulnerable people Level 3</td>
<td>8</td>
<td>15</td>
<td>53.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust reported some data quality issues when returning the request for compliance with protecting vulnerable people level 2 for medical staff. This meant that we were not assured if staff had completed this as required.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We raised concerns with the management team during the inspection that records provided prior to the inspection showed that most staff had not completed mandatory training appropriately. As a result we were provided with the updated data to indicate that some improvements had been made for both nursing and medical staffing groups.

The breakdown of protecting vulnerable people training completion from April to October 2017 for nursing staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting vulnerable people Level 2</td>
<td>46</td>
<td>92</td>
<td>42%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Protecting Vulnerable People - Level 3</td>
<td>77</td>
<td>102</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The breakdown of protecting vulnerable people training completion in February 2018 for medical staff in urgent and emergency care at the trust is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting Vulnerable People - Level 2</td>
<td>13</td>
<td>16</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Protecting Vulnerable People - Level 3</td>
<td>13</td>
<td>15</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Cleanliness, infection control and hygiene**

We found some areas of the department to be visibly dirty. For example, in the majors area we observed dirty sinks as well as dirty equipment such as a bladder scanner and blood stained monitoring equipment being reused without being cleaned. In the minor injuries area we observed dirty linen on the floor and in the ophthalmology room we observed the lamp used for examination to be visibly dirty. We also observed a number of occasions when staff did not clean equipment following use.

We checked a sample of disposable curtains for cubicles, finding that they did not have expiry dates. Cleaning staff informed us that there were no formal arrangements for curtains to be changed. This meant that there was an increased risk of infection being spread.

Staff had access to cleaning equipment, however, we found that the sluice room was unlocked which meant that there was a risk that cleaning equipment could be accessed by members of the public. This included corrosive substances such as disinfectant.

Mattresses were visibly clean and free of damage. We observed staff cleaning mattresses following use and changing linen in between patient use.

There were hand gel dispensers at the entrance and exit points to all main areas and each cubicle had a sink. Hand gel dispensers were also available inside each cubicle. However, we observed four members of staff providing care and treatment to different patients without decontaminating their hands in between.

Staff had regard to ‘bare below the elbow’ requirements in line with trust policy. We saw that all staff adhered to this on the days of the inspection.

We observed staff cannulating patients (a cannula is a plastic tube used to administer medicines) on four occasions, finding that best practice guidance was followed on all occasions. This included staff wearing clinical gloves before undertaking the procedure.

Staff informed that they managed infectious patients in doored cubicles when possible. However, the department only had access to two doored cubicles which meant that this was not always possible, particularly at times when the department was busy.

Staff had access to personal protective equipment when needed. This included gloves and aprons for use when providing care and treatment. Staff we spoke with were able to describe when they would use this.

Housekeepers were available during normal working hours. An out of hours service was also available 24 hours a day, seven days a week if required. However, housekeeping staff informed us that they did not complete checklists to document what had been cleaned. This meant that there was a risk of staff in the department not being aware if there were areas that still required cleaning.
Between January 2017 and January 2018, the department had not reported any incidents of patients developing methicillin-resistant staphylococcus aureus, methicillin-sensitive staphylococcus aureus or clostridium difficile.

**Environment and equipment**

The emergency department was located at the front of the hospital. The reception area, triage, minor injuries and resuscitation areas were located in a section of the department that had been recently built. This had been done in line with the Health Building Note 15-01 (guidance for planning and designing accident and emergency departments). The majors and paediatric areas as well as the emergency department review unit were located in the original part of the hospital.

There was easy access to diagnostics, with the x-ray and computerised tomography (CT) departments being located nearby. There was also easy access to critical care and theatres when needed.

The waiting room was large and provided seating for a large number of people. This was important as the department was busy on a regular basis.

Most areas in the department were well maintained. However, some areas of the department were cluttered and equipment was not always stored appropriately. For example, in the emergency department review unit, monitors were stored in between patient cubicles and nursing stations. This presented a potential hazard to both staff and patients.

We found that not all areas of the department were restricted appropriately. For example, although the children’s department had lockable doors, this area was not secured, meaning that there was a risk that unauthorised people would be able to enter or that children would be able to abscond unnoticed.

Resuscitation trolleys were available in all areas of the department. We checked these, finding that they had the correct equipment and records indicated that they had been checked on most occasions. However, there had been four occasions in March 2018 when equipment in the children’s area had not been checked in line with trust policy. In addition, we noted that these trolleys did not have tamper seals. This was important as tamper seals are used so that staff know in the event of an emergency, equipment had not been tampered with since it was last checked.

We sampled several pieces of equipment and found that on most occasions there was evidence of a portable appliance test and a service being carried out appropriately. However, we found three pieces of equipment that were overdue portable appliance testing and service.

The trust had an electronic biomedical engineering department which held an asset register for all equipment in the department. Records indicated that 35% of equipment was overdue portable appliance testing or a service. It was unclear if many of these items were still in the department as some had last been serviced between 2014 and 2016. This meant that there was a risk that there were pieces of equipment being used in the department or elsewhere in the hospital without having been tested for safety.

There were systems in place to manage and dispose of clinical and non-clinical waste. Sharps boxes were also available. However, on two occasions we observed full sharps boxes being left open and unattended in the department.

Patient led assessments of the care environment were completed on a regular basis. However, data was only available for the trust as a whole. This meant that it was unclear if any
improvements were required as there was no data available for the emergency department specifically.

The section 136 part of the emergency department was offset from the main accident and emergency area in order to provide privacy for those detained under section 136. It comprised of three rooms which had anti-barricade doors. One of the rooms had dual entry and also contained a toilet and a sink. Ligature alarms were on the top of the doors. There was no clock available so that detainees were able to orientate themselves in time; however, the matron undertook to remedy this immediately.

The first safe room had two doors, one with an observation panel to assist with observing patients. One of the doors opened outwards which prevented patients from barricading themselves in the room. The second safe room (which staff told us was primarily used as an assessment/interview room had only one door which opened both ways and a control panel of glass for observations and privacy. There was no strip alarm in either room.

The safe rooms did not have any ligature points. Ligature points are places to which a cord, rope or other material could be attached for the purposes of hanging or strangulation.

All rooms were equipped a heavy chair and large sofa. These were specially designed to be weighted to prevent patients from picking them up and throwing them.

Assessing and responding to patient risk

The department used a system to prioritise patients. We sampled 12 patient records, finding that this system had been used appropriately on ten occasions. However, on two occasions, a full set of observations had not been completed. This meant that there was a risk that these patients had not been triaged fully and would be prioritised incorrectly.

The department had a designated triage area. The management team had recently agreed to increase the planned number of staff in the triage area to three registered nurses. This was so that there was a registered nurse available to triage patients from the waiting room, a registered nurse to triage patients who had attended by ambulance and another registered nurse to manage patients in the minor injuries area. However, we reviewed rotas for March 2018, finding that there had been 20 occasions that the planned number of staff in the triage area had not been met.

During the inspection, we observed patients waiting for up to two hours to receive an initial assessment by the triage nurse. This meant that there was a risk that a patient’s condition would deteriorate further prior to receiving an initial assessment by a clinician. For example, we observed a patient who had collapsed at home having to wait for two hours for an initial assessment.

Median time from arrival to initial assessment (for patients who self-present only)

Records indicated that between March 2017 and February 2018, the department had continually struggled to meet the Royal College of Emergency Medicine standard for all patients to be triaged within 15 minutes of arrival. Compliance during this period varied between 32% and 46%.

The average time to initial assessment during the same period varied between 21 and 34 minutes.

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was worse than the overall England median for all 12 months from January 2017 to December 2017.

The trust median time from arrival to initial assessment varied across the twelve month period from 16 minutes to 23 minutes whereas the England range was much smaller varying from six minutes to nine minutes.
Ambulance – Time to initial assessment from January 2017 and December 2017 at Wirral University Teaching Hospital NHS Foundation Trust

(Source: Source: NHS Digital - A&E quality indicators)

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for nine months over the 12 month period from January 2017 to December 2017.

The trust’s performance improved from August 2017 onwards. The average median time to treatment from January 2017 to July 2017 was 90 minutes compared to 61 minutes for the period August 2017 to December 2017.

Ambulance – Time to treatment from January 2017 to December 2017 at Wirral University Teaching Hospital NHS Foundation Trust

(Source: Source: NHS Digital - A&E quality indicators)

The department used a modified early warning score system to identify deteriorating patients in the department. This was based on a number of basic observations including blood pressure, heart rate and temperature. There were clear actions for staff to take depending on the modified early warning score. This included monitoring patients on a more regular basis or escalating them for an immediate medical review.
Modified early warning scores were recorded on the electronic system and were displayed on electronic boards in each area of the department. This meant that staff were able to easily identify patients who had deteriorated.

We reviewed ten sets of records for adults, finding that modified early warning scores had been completed correctly on eight occasions. However, we found two occasions when patient’s observations had not been retaken in a timely manner and in line with trust policy.

We sampled ten patient records, finding that the falls risk assessment had not been completed on any occasions. On one occasion, we observed a patient in the emergency department review unit who was visibly unsteady when walking. We found that his patient had an increased risk of falls due to their medical condition and that a risk assessment had not been completed. This presented an increased risk of patient harm.

In addition, we also found that pressure ulcer risk assessments had not been completed on any occasions for patients who had spent longer than six hours in the department. This was not in line with trust policy or guidance from the National Institute for Health and Care Excellence.

Staff were required to complete patient safety checklists for all patients who attended the department. We found that this had only been partially completed in three out of ten records that we reviewed. This was particularly important as a high number of patients remained in the department for over 12 hours.

The department were not always able to ensure that there was a member of staff available with advanced paediatric life support on every shift. This was because records indicated that there had only been eight members of nursing and medical staff trained. In addition, the management team did not use a system to identify whether there was an appropriately trained member of staff on every shift. However, records provided following the inspection indicated that there was always a member of staff available in the wider hospital to cover this shortfall.

There was 24 hour, seven days a week access to children’s services, including medical staff. We requested evidence that there were sufficient numbers of medical staff trained in advanced paediatric life support from the children’s service but the trust were unable to provide us with this information. This meant that it was unclear if there would always be a member of staff available who was trained in advanced paediatric life support.

The children’s department was open from 8am to 11pm between Sunday and Thursday as well as from 9am to midnight on Friday and Saturday. We were informed that the paediatric team from the children’s and young people’s service were easily accessible outside of these hours. Staff informed us that they were responsive and attended the department when required. We saw one example when the paediatric team responded quickly to an emergency in the department.

The department used a paediatric early warning score system for children who attended the department. However, we found that this system was used inconsistently. We sampled five records for children who had attended when the children’s department was open, finding that the paediatric early warning system was calculated correctly on all occasions. In comparison, we sampled four records for children who attended out of hours, finding that the paediatric early warning score system had only been used correctly on one occasion.

There was a resuscitation area in the department which was used to manage medical emergencies. This area had a total of eight beds and was equipped to provide treatment to both adults and children. The department had introduced a four bedded high dependency area for patients who no longer required management in the resuscitation area but still required monitoring. This area was equipped with cardiac monitoring equipment. In addition, the children’s department
also had two emergency rooms that were used to monitor children who no longer required treatment in the resuscitation area.

A sepsis screening tool was used to support staff in recognising patients with potential sepsis. This was important as sepsis is a life threatening condition when infection travels to other parts of the body in the bloodstream and requires timely medical intervention.

The management team had introduced a sepsis pathway for staff to follow when providing treatment to patients with potential sepsis. We reviewed four records of patients who had been identified as high risk, finding that treatment had been given in a timely manner on all occasions. However, we noted that although treatment had been documented in patient records, the sepsis pathway had not been completed on three of these occasions. This meant that there was an increased risk that some elements of care would be potentially missed.

An electronic system was used to identify what part of the department patients were currently being managed in. However, staff informed us that there had been occasions when a patient had been discharged from the electronic system but were still present in the department as they were waiting for diagnostic results to be returned. This meant that there was a risk of patients not being monitored appropriately by staff during this period. An example of this was if a patient met the criteria to be moved to the emergency department review unit but there were no beds available.

The trust had an overall escalation plan which highlighted key actions for staff in different departments to take when there was increased demand. In addition, the management team had developed an overcrowding policy which was in draft at the time of inspection. This was important as it determined local actions to be taken at times of increased pressure.

The management team had also implemented a standard operating procedure for the safe management of patients in the corridor. This included an exclusion criteria for managing patients in this area as well as the staffing requirements. However, we found that knowledge of this operating procedure was mixed. This meant that there was an increased risk that this would not always be followed.

There was a risk that if there was a major incident, all equipment would not be present or staff would not be able to access it in a timely manner. This was because when requested, staff were unable to locate the keys to access the equipment in a timely manner. Additionally, there was no checklist to ensure that all equipment in the container was present. Major incident equipment was kept in a container outside of the department and included equipment such as decontamination suits and a decontamination tent.

The department was a major trauma unit. There was a trauma team available in the hospital, along with a clear inclusion and exclusion criteria for patients and a clear pathway for patients to be referred to a major trauma centre when required.

We reviewed audits completed by the trauma audit and research network for November 2017 and March 2018. Results from these indicated that the department had continually struggled to meet the target for patients being seen within five minutes of arrival by a consultant.

Staff also had access to a number of pathways to other services internally and externally, including critical care, stroke services as well as primary percutaneous coronary intervention services (primary percutaneous coronary intervention is a procedure where a small plastic tube is inserted into a patient’s artery to restore blood flow when a patient is having a heart attack).
Emergency Department Survey 2016

The trust’s scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>8.5</td>
<td>About the same as other</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>department staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>7.0</td>
<td>About the same as other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td>6.7</td>
<td>About the same as other</td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did you wait before</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>being examined by a doctor or nurse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>9.1</td>
<td>About the same as other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel</td>
<td>9.7</td>
<td>About the same as other</td>
</tr>
<tr>
<td>threatened by other patients or visitors?</td>
<td></td>
<td>trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

There was a mental health and deliberate self-harm pathway which used a traffic light system to assess risk. This was followed up with a clinician assessment tool again highlighting the risk. Clear actions were outlined such as contacting psychiatric liaison and the provision of one to one supervision for those patients assessed as red.

There was also a missing patient action check list for staff to follow as well as a policy in place. Descriptions of patients considered to be at risk were taken.

There was a policy in place that the psychiatric liaison team would only see a patient in the emergency department once any physical needs had been addressed.

The reception staff were in possession of a ‘frequent patients’ folder which contained care plans and immediate actions that should be taken to support staff in preventing patients becoming unduly agitated.

The management team had responded to a regulation 28 report that had been issued by the coroner (a regulation 28 report is sent from the coroner following an investigation into incidents to prevent future deaths). This had been related to the inappropriate discharge of a patient with mental health issues. We found that the discharge process had changed as a result of this.

Provision for children’s mental health was not as comprehensive. Any young person under 16 with a mental health issue presenting at the department was not seen by a representative from the child and adolescent mental health service professional unless they were admitted into the hospital. This meant that any child entering the emergency department on a Friday evening would not see a mental health professional until the Monday.

Staff in the department informed us that they did not have any problems accessing inpatient beds for this purpose when needed.
Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

From January 2017 to December 2017 the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Arrowe Park Hospital varied.

Following a downward trend from February to April 2017, the percentage then increased from May to August 2017. A further downward trend was seen from September to November 2017, followed by an increase in December 2017 up to 63%.

Ambulance: Number of journeys with turnaround times over 30 minutes - Arrowe Park Hospital

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Arrowe Park Hospital

(Source: National Ambulance Information Group)

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From December 2016 to November 2017 the trust reported 1,809 “black breaches”. Higher numbers of black breaches were reported from December 2016 to February 2017 and from May to August 2017, with a particularly high number reported in July 2017 (347). The trust reported much lower numbers of black breaches in the latest three months from September (42 black breaches) to November 2017 (80 black breaches).
All cubicles had call bells available so that patients were able to alert staff if they required immediate assistance. We found that these were used appropriately.

Receptionists that we spoke with were aware of actions to take if a patient self-presented. We were given examples of conditions that were escalated to the triage nurse immediately.

The trust had access to a security team who were available 24 hours a day, seven days a week. Staff informed us that the security team were responsive and attended quickly when needed. We observed two occasions when a member of security staff was required to monitor patients, finding that they responded quickly on both occasions.

### Nurse staffing

The nursing establishment had last been calculated two years ago using a formal acuity tool. However, the number of nurses required to staff the department safely had changed since the last review due to the new environment and the increased demand that the service faced. The senior management team informed us that a full review of nurse staffing was currently being completed.

The department had been established to have a supernumerary shift leader (not included in the staffing numbers), 13 registered nurses during the day and 11 registered nurses during the night. The management team had recently agreed to have two extra registered nurses to support the triage area and the corridor due to increased demand. However, the overall establishment had not yet been adjusted to reflect this.

We reviewed staffing rotas for March 2018, finding that the planned number of registered nurses had not been achieved on any occasion against the planned number of registered nurses that the management team had identified to keep the department safe. In addition, records indicated that the shift leader had been included in the staffing numbers on a regular basis. We observed two occasions when this happened during the inspection. This was important as shift leaders were responsible for maintaining access and flow through the department as well as supporting staff to maintain patient safety.

We had concerns that not all incidents of staff shortages had been reported appropriately. We reviewed staffing incidents that had been reported for all areas of the trust during the same period, finding that there was no reference to the majority of occasions when the planned establishment had not been met in the department. We also reviewed a staffing report that was sent to the assistant director of nursing, finding that although staffing levels for the emergency department review unit were included, staffing levels of other parts of the emergency department...
were not.

More importantly, there was no evidence that incidents had been reported on occasions when a number of beds had been closed in the department due to short staffing. Between October 2017 and March 2018, records indicated that ‘red flag’ staffing incidents had been reported on only 11 occasions.

In addition, the trust had an escalation policy which included how staffing issues should be escalated so that an appropriate response could be co-ordinated by a member of the senior management or the executive team. However, we were not assured that this was always followed so that any potential risks during periods of short staffing were reduced as much as possible.

For example, on the four occasions during February and March 2018 when beds in the department had been closed, we did not see any evidence that this decision was made by an appropriate member of staff as outlined in the escalation policy. This meant that there was an increased risk to patient safety in the department at these times.

Following the inspection, the senior management team informed us that this decision had been made by an appropriate member of staff. However, there was no documented evidence to support this as these decisions had not been formally recorded.

We reviewed rotas for March 2018, finding that the planned number of clinical support workers had not been achieved on most occasions. Clinical support workers were important as they supported registered nurses to provide care and treatment to patients. Some clinical support workers were able to perform clinical skills such as taking blood or providing catheter care.

The department did not meet the Royal College of Emergency Medicine or the Nursing and Midwifery Council standards which state that there should be a registered children’s nurse available in the department at all times. This was because the children’s department was closed between 11pm and 8am from Sunday to Thursday as well as between midnight and 9am on Friday and Saturday. During these times children were managed by adult trained nurses.

The service employed one registered children’s nurse, a paediatric emergency nurse practitioner as well as a paediatric advanced nurse practitioner. They were supported by three other members of nursing staff who had completed further children’s training to provide care and treatment to children. We were informed that an additional registered children’s nurse had been recruited but had not yet started.

The department was also funded to provide an emergency nurse practitioner between 8.30am and midnight and an advanced nurse practitioner between 8am and 10pm seven days a week. Nurse practitioners have extended skills and are able to see, treat and discharge specific groups of patients without them needing review by medical staff.

**Vacancy rates**

From November 2016 to October 2017, the department reported a vacancy rate of 4.6%. The trust does not have a target vacancy rate.

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

**Turnover rates**

From November 2016 to October 2017, the department reported a turnover rate of 5.5%. This met the trust target of the turnover rate being less than 10%.

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*
Sickness rates

From November 2016 to October 2017, the department reported a sickness rate for nursing staff of 6.8% which was higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

From November 2016 to October 2017, the trust reported 975 shifts filled by bank staff (2.2%) and 92 shifts filled by agency staff (0.2%) in urgent and emergency care. There were 1,103 shifts not filled by bank or agency staff (2.5%).

A breakdown of bank and agency usage by staff type is shown below:

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>420 (5.8%)</td>
<td>555 (1.5%)</td>
<td>975 (2.2%)</td>
</tr>
<tr>
<td>Agency</td>
<td>0 (0.0%)</td>
<td>92 (0.3%)</td>
<td>92 (0.2%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>270 (3.7%)</td>
<td>833 (2.3%)</td>
<td>1103 (2.5%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

The trust had a policy for the use of bank and agency staff. This stated that all bank and agency staff must have a local induction before starting fully. This was important as local inductions support bank and agency staff to follow the correct policies and procedures in the department. The management team informed us that this had been completed when needed. However, we did not see any evidence of these having been completed.

All nursing staff attended a safety huddle at the start of each shift. This meeting was used to discuss topics including concerns that had been raised in the department or any changes in practice. We also observed a full nursing handover, finding that this was structured and informative.

Medical staffing

There was a lead consultant for the department and there was a separate lead consultant for children who had sub speciality training for children. This was important as there had been 25,000 child attendances to the department in the last 12 months.

The department was funded for consultants to be available on site between 8am and midnight, seven days a week. An on call consultant was also available out of hours.

We reviewed the medical rotas for March 2018, finding that the planned number of consultants had been achieved on all occasions.

The department had also planned for middle grade doctors of different seniority to be present in the department 24 hours a day, seven days a week. However, we found that there were insufficient numbers of middle grade doctors with sufficient seniority to cover all shifts.

An investigation that had been completed into a serious incident reported in July 2017 had identified that the most senior member of medical staff in the department out of hours was a ST3. This did not meet the Royal College of Emergency Medicine standard which states that a minimum of an ST4 must be present in the department at all times (ST3 and ST4 refers to the seniority of middle grade doctors within the department).

The management team informed us that an extra consultant now remained on site at times when this had not been achieved. We reviewed medical rotas for March 2018, finding that this had been the case. However, staff who we spoke with had concerns that this way of working was
unsustainable. In addition, there was limited evidence that any action had been taken by senior managers to address this concern in the longer term.

Records for March 2018 indicated that the planned number of middle grades had been achieved on 21 out of 31 occasions. However, records for the same period also indicated that the planned number of junior doctors had only been achieved on six out of 31 occasions.

The department employed a consultant who had sub speciality training in paediatrics. This met the Royal College of Emergency guidance which states that departments seeing over 15,000 children per year should have a consultant who specialised in paediatrics.

We attended a medical handover, finding that this was thorough and informative. We found that the medical handover was attended by all appropriate members of the medical team, and all patients in the department were discussed.

All medical staff, including locums were required to attend a trust induction as well as completing all mandatory training modules. In addition, locum doctors were required to complete a local induction which was important as it was an opportunity to orientate them to the systems and processes that were used in the department. However, we did not see any documented evidence that local inductions had been completed when required.

The trust reported the following medical staffing numbers for urgent and emergency care in March and October 2017:

<table>
<thead>
<tr>
<th>Time period</th>
<th>Actual WTE Staff in post</th>
<th>Planned WTE Staff in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>31.0</td>
<td>56.0</td>
</tr>
<tr>
<td>October 2017</td>
<td>31.4</td>
<td>56.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

From November 2016 to October 2017, Arrowe Park Hospital reported a vacancy rate for medical staff in urgent and emergency care of 40.2%. The trust does not have a target vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From November 2016 to October 2017, Arrowe Park Hospital reported a turnover rate for medical staff in urgent and emergency care of 18.9%, which was higher than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From November 2016 to October 2017, Arrowe Park Hospital reported a sickness rate of 1.4% for medical staff in urgent and emergency care which was lower than the target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and locum staff usage

Please note that the trust did not provide the total shifts available for middle grade doctors so we are unable to calculate bank and locum usage overall or for this staff type as a proportion of the total shifts including permanent staff.

From November 2016 to October 2017, the trust reported 4,005 shifts filled by bank staff and 503 shifts filled by locum staff in urgent and emergency care at Arrowe Park Hospital. There were 22 shifts not filled by bank or agency staff.

A breakdown of bank and locum usage by staff type is shown below:

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Consultant</th>
<th>Middle grade</th>
<th>Doctor in training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>219</td>
<td>210</td>
<td>3,576</td>
<td>4,005</td>
</tr>
<tr>
<td>Locum</td>
<td>173</td>
<td>330</td>
<td>0</td>
<td>503</td>
</tr>
<tr>
<td>Not filled</td>
<td>10</td>
<td>12</td>
<td>0</td>
<td>22</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

As of October 2017, the proportion of consultant staff reported to be working in urgent and emergency care at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 36 whole time equivalent staff working in urgent and emergency care.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>19%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*</td>
<td>39%</td>
<td>23%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Records

The emergency department used a combined electronic and paper based system for patient records. Paper based records included an initial triage sheet, a patient safety checklist and risk assessments. The electronic records contained all patient information, including alerts for safeguarding, infection control risks, patient observations and medication charts.
The electronic system used in the department was different to the system that was used in all other areas of the hospital. Most information was transferable from one system to another. However, we found that patient observations and national early warning scores that had been completed in the emergency department could not be accessed in other areas of the hospital, for example, in the emergency department review unit as well as other areas of the hospital. The trust had plans to fully integrate all electronic records within the next 12 months.

We reviewed a sample of 11 records for both adults and children. We found that all paper records had been dated and signed. Also, the time of triage and when treatment was started was clearly documented. Electronic records logged the pin number of the member of staff who had made additional entries.

We also found that all paper records for patients were kept securely at nursing stations to protect patient confidentiality.

The management team had responded to a regulation 28 report that had been issued in 2016 (a regulation 28 report is sent from the coroner following an investigation into incidents to prevent future deaths). This was related to the poor transfer of care of a patient between the emergency department and an inpatient area of the hospital which included patient information on records.

The trust had responded to this by implementing a standard operating procedure to support staff when handing over information as well as the trust policy for the transfer of care being amended. Staff we spoke with were aware of the standard operating procedure but acknowledged that there were continued issues with non-compliance against this. Staff also informed us that this was mainly due to how busy the department was and that face to face handovers to staff in other areas of the hospital had not always been achieved.

We also noted that although the transfer of care policy had been amended for adults, it had not been for children. This meant there was an increased risk that all required documentation for children would not be transferred fully to inpatient areas of the hospital when needed.

The senior management team had introduced daily audits to measure compliance against the standard operating procedure. We reviewed a random sample of daily audits for March which indicated that average compliance with this was only 70%. More importantly, it was unclear what actions were being taken to improve compliance with this.

We also took time to observe three patient transfers to the inpatient ward, finding that these were done appropriately on all occasions. However, we sampled records of three additional patients, finding that on two occasions staff in inpatient areas did not have access to all patient records that had been completed in the emergency department.

Records were scanned into the electronic system when a patient was discharged. This meant that this information was easily accessible if a patient re-attended. Information of all attendances were shared with the appropriate general practitioner.

**Medicines**

The Trust had a medicines management policy which was available to all staff on the intranet.

Staff informed us that pharmacists visited the department three times per week and were responsible for replenishing drugs. We saw evidence of stock rotation which meant that the risk of medicines expiring was reduced.
Clinical rooms were available in each area of the department and had restricted access. Staff used these areas to prepare medicines for administration.

We found that controlled drugs had not always been managed in line with trust policy and legislation. This was because we sampled records of controlled drugs in the minor injuries, majors and resuscitation areas of the department, finding that in majors, there had been 16 occasions when the dose administered was not signed for and 18 occasions when the amount of drug administered had not been documented. In minor injuries, there had been seven occasions when the amount of drug administered had not been documented and on four occasions had not been signed for. In resus there were two occasions when morphine had been administered but had not been signed for.

However, we did note that controlled drugs were stored securely and the amount of controlled drugs present tallied with the amount that had been documented in the controlled drugs register.

Nursing staff were able to administer a number of medicines by following a patient group direction. Patient group directions allow nursing staff to administer medicines without the need for a prescription.

Records indicated that these had not been completed in line with the trust medicines management policy or legislation. This was because when reviewing the most updated patient group directions we found that not all staff and clinical managers had signed the register. For example, records for administering intravenous (a therapy that delivers liquid substances directly into a vein) paracetamol and hartmans fluid indicated that all staff had signed the record but none had been signed by a clinical manager.

Additionally, we found that records authorising advanced nurse practitioners to prescribe medicines were also out of date. We sampled two of these, finding that one had expired in June 2017 and the other in November 2017. However, the advanced nurse practitioners were aware of what medicines they were allowed to prescribe and informed us that they would refer any other cases to a member of medical staff.

Medicines requiring storage at low temperatures were kept in fridges. Fridge temperatures across the department were found to be in correct range and checked regularly.

We checked a sample of other medicines and found them to be in date and stored in locked areas. This included fluids such as sodium chloride and dextrose.

The emergency department used electronic medication charts to record patient’s own medicines, as well as medicines that had been prescribed and administered. We sampled five medication charts, finding that allergies were documented and they had been completed correctly on most occasions. However, we found one occasion when a medicine had been prescribed and administered but had not been recorded on the electronic system. We raised this with a member of medical staff who were unable to explain why this had happened.

Arrangements were in place to reconcile patient’s own medicines that were brought into the department. We saw examples of patient’s own controlled drugs being locked in the controlled drugs cupboard and a record of these had been made correctly.

In the event of patients being admitted to an inpatient ward, prescribed medicines were transferred on the electronic system that was used throughout the rest of the hospital.
Incidents

The trust had an incident reporting policy that was available on the intranet.

The department used an electronic reporting system. Staff that we spoke with knew how to use the system. The type of incidents that staff had reported included near misses and incidents that had resulted in patient harm. However, staff informed us that they had not always received feedback when they had reported incidents.

Members of the management team informed us that a lot of work had been undertaken with staff to encourage them to report incidents. We were given examples when staff had not reported incidents as they were scared of being blamed. The management team felt that improvements had been made in regard to this.

We saw evidence that governance newsletters for the department were issued to staff on a monthly basis and included information about incidents that had been reported.

Records indicated that 250 non clinical and clinical incidents had been reported between October 2017 and March 2018. Of these, 29 had been reported as near misses, 177 had resulted in no patient harm, 41 in low harm, and three in moderate harm.

We had concerns that serious incidents were not being reported or fully investigated in line with the NHS Serious Incident Framework 2015.

Serious incidents had not always been identified in a timely manner. The NHS Serious Incident Framework 2015 states that all serious incidents must be reported within 48 hours of them happening. We found that between January and December 2017, only two had been reported within 48 hours.

We randomly sampled three of the serious incidents that had been reported during this period, finding that on two occasions a full root cause analysis had not been completed. This was important as a root cause analysis is a tool used to investigate incidents fully so that actions can be implemented to reduce the risk of a similar incident happening again.

The trust was unable to provide us with information about which serious incidents in the department had progressed to a full root cause analysis. This meant that it was unclear if full investigations had been undertaken for all serious incidents that had been reported.

However, we noted that a 72 hour review had been completed for each of these incidents. A 72 hour review is an initial investigation into serious incidents which provides an opportunity for immediate actions to be implemented if required, although this is not the same as a full root cause analysis investigation.

We were informed that when a serious incident had been identified they were discussed by a trust wide serious incident panel. This was led by members of the senior management team who made the decision whether root cause analysis investigations should be completed. We reviewed minutes from two of these meetings, finding that there was no documented reason for a full investigation not being undertaken.

Breakdown of serious incidents reported to STEIS

The trust reported 13 serious incidents in urgent and emergency care which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were:

- Diagnostic incident including delay meeting the serious incident criteria (including failure to act on test results) with four (31% of total incidents)
- Treatment delay meeting the serious incident criteria with three (23% of total incidents)
• Slips/trips/falls meeting the serious incident criteria with two (15% of total incidents)
• Abuse/alleged abuse of child patient by staff with one (8% of total incidents)
• Abuse/alleged abuse of child patient by third party with one (8% of total incidents)
• All other categories with one (8% of total incidents)
• Medication incident meeting the serious incident criteria with one (8% of total incidents)

(Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017))

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 January 2017 to December 2017, there were no incidents which were classified as never events for urgent and emergency care at the trust.

(Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017))

The management team had responded to two separate regulation 28 reports that had been issued by the coroner (a regulation 28 report is sent from the coroner following an investigation into incidents to prevent future deaths). One of these had been related to the transfer of care of a patient from the department to an inpatient area of the hospital. The other was relating to the inappropriate discharge of a patient with mental health issues.

The trust had a policy for the Duty of Candour. 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.

We had concerns that Duty of Candour had not always been applied when needed. In addition, members of the management team did not have a full understanding of when Duty of Candour was required. Managers told us that they would only apply Duty of Candour if a root cause analysis had been completed. This was not in line with the regulatory requirement which states that it should be applied for all notifiable patient safety incidents that had resulted in a moderate level of harm or above.

Mortality reviews were undertaken for all deaths that had occurred in the department. Mortality reviews are important as they facilitate learning from deaths that have happened in the department, particularly in cases when a death may have been avoidable. We saw evidence of
mortality reviews being presented at departmental clinical governance meetings. However, we noted that five of these meetings had been cancelled between April 2017 and March 2018, which meant that it was unclear if mortality reviews had been completed during this period.

**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 no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from December 2016 to December 2017 within urgent and emergency care.

*(Source: Safety thermometer - Safety Thermometer)*

We also requested information about the total number of patient harms, including falls and pressure ulcers between April 2017 and March 2018. The trust was unable to provide us with this information for the department. This meant that we were unsure if accurate information about the number of patient harms in the department was being recorded appropriately.

### Is the service effective?

**Evidence-based care and treatment**

Staff had access to up to date evidence based guidance from organisations such as the National Institute for Health and Care Excellence and the Royal College of Emergency Medicine. However, not all staff were aware of best practice guidance, particularly regarding Royal College of Emergency Medicine standards. For example, the majority of medical staff that we spoke with did not have an understanding of conditions that had to be reviewed by a consultant before patients were discharged.

A number of clinical pathways were used to support staff in complying with all aspects of best practice guidance when treating adults. This included pathways for acute kidney injury, fractured hip and chest pain of cardiac origin.

However, we found in four out of five records that had required the use of a patient pathway, the appropriate documentation had not been completed. This meant that although most elements of care had been documented in free text, there was a risk that not all elements of care pathways had been met.

The trust had recently undertaken a review of pathways and protocols across the hospital which had identified some areas where current information that was available did not reflect the most up to date best practice guidance. Examples of this that were applicable to the emergency department were ‘managing challenging behaviour and people with learning disabilities’ (NG11), ‘Pneumonia: diagnosis and management of community and hospital acquired pneumonia in adults’ (NG191) as well as diabetes (type 1 and type 2) in children and young people: diagnosis and management (NG18). This meant that there was a risk of care and treatment provided for some
conditions would not be delivered in line with best practice. Members of the management team informed us that the trust had made plans to amend these.

In addition to pathways, staff had access to best practice guidance on the intranet. This included protocols for a large number of other conditions and disorders. We sampled a number of these, finding them to be current and up to date.

The emergency department submitted data to the Royal College of Emergency Medicine on a regular basis so that patient outcomes could be compared nationally. However, the management team did not complete any other audits that monitored compliance with other protocols that were not included in the Royal College of Emergency Medicine standards.

**Nutrition and hydration**

The department used a nutritional assessment tool to assess patients. This type of assessment identifies patients who might be at risk of malnutrition and allow for a referral to appropriate professionals for ongoing support. We reviewed records for two patients who had required assessment, finding that this had been completed on one occasion.

Patients who spent extended periods of time in the department were provided with drinks and snacks. However, there had been no arrangements made for hot food to be provided in any areas of the department.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 7.4 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

*(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)*

**Pain relief**

The department had access to a variety of medications used for pain management. Pain scoring tools were used for both adults and children. However, we noted that the children’s department did not use a modified pain scoring tool that could be used for younger children. This was important as there was a risk that younger children would not be able to fully communicate how much pain they were in.

We were not assured that pain was assessed consistently and that pain relief had been administered appropriately, particularly for children.

We sampled four patient records for adults when a pain score had been required, finding that a pain score had not been documented on any occasion. This included two occasions when pain relief had been administered. We also found that on the occasions when pain relief had been given, there was no documented evidence that pain relief had been reassessed to measure whether the treatment had been effective.

We also sampled five patient records for children when a pain score had been required. We found that a pain score had been documented on two of these occasions. On three of the five occasions we found that no pain relief had been administered despite there being documented evidence of discomfort in the patient’s medical records.
The department did not use a tool to assess the pain score for patients who were not able to communicate, such as patients with cognitive impairment. This meant that there was an increased risk that pain relief would not be given appropriately for this group of patients.

Nursing staff had access to and were allowed a small number of medicines used for pain relief following a patient group direction. These allow nursing staff to administer medicines without the need for a prescription. This meant that pain relief could be administered to a patient on initial presentation and before they had been reviewed by a member of the medical team.

The trust had a specialist pain management team who were available between Monday and Friday, during normal working hours.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 5.9 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.

The trust scored 8.0 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

*(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)*

**Patient outcomes**

**RCEM Audit: Moderate and Acute Severe Asthma 2016/17**

In the 2016/17 Moderate and Acute Severe Asthma report, the trust did not meet any of the national aspirational standards for the seven fundamental metrics.

The trust performed better than other trusts in the following three fundamental metrics:

- Standard 5a: If not already given before arrival to the ED, steroids should be given within one hour (acute severe). Trust: 57%; UK: 19%.
- Standard 5b: If not already given before arrival to the ED, steroids should be given within four hours (moderate). Trust: 59%; UK: 28%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed according to guidelines. Trust: 86%; UK: 52%.

The trust performed worse than other trusts in the following two fundamental metrics:

- Standard 1a: O2 should be given on arrival to maintain sats 94-98%. Trust: 12%; UK: 19%.
- Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Trust: 12%; UK: 25%.

The trust performed similar to other trusts in the following two fundamental metrics:

- Standard 2a: Vital signs should be measured and recorded on arrival at the ED. Trust: 32%; UK: 26%.
- Standard 4: Add nebulised Ipratropium to nebulised β2 agonist bronchodilator therapy. Trust: 83%; UK: 77%

*(Source: Royal College of Emergency Medicine)*
RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, the trust did not meet any of the four national aspirational standards.

The trust performed worse than other trusts in the following three metrics:

- A traumatic chest pain in patients aged 30 years and over (seen by a Consultant). Trust: 0%; UK: 11%.
- Fever in children under 1 year of age (seen by a Consultant). Trust: 0%; UK: 8%.
- Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge (seen by a Consultant). Trust: 0%; UK: 12%.

The trust performed similar to other trusts in the following metric:

- Abdominal pain in patients aged 70 years and over (seen by a Consultant). Trust: 9%; UK: 10%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

Comparing this provider to other trusts on the 2016/17 Severe Sepsis and Septic Shock Audit, performance was worse in three metrics and similar in five metrics. In this context, 'similar' means that the trust's performance fell within the middle 50% of results. The national standard was not met for any of the eight of the relevant metrics.

The trust performed worse than other trusts in the following three metrics:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. Trust: 14%; UK: 69%.
- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Trust: 5%; UK: 30%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Trust: 4%; UK: 18%.

The trust performed similar to other trusts in the following five metrics:

- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Trust: 59%; UK: 65%.
- Standard 4: Serum lactate measured within one hour of arrival. Trust: 51%; UK: 60%.
- Standard 5: Blood cultures obtained within one hour of arrival. Trust: 55%; UK: 45%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Trust: 27%; UK: 43%.
- Standard 7: Antibiotics administered: Within one hour of arrival. Trust: 29%; UK: 44%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Vital signs in children 2015/16

In the 2015/16 Vital signs in children audit, the trust did not meet any of the national standards.

The trust performed better than other trusts in the following three metrics:

- Standard 1a. All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score. Trust: 54%; England: 38%.
- Standard 2 (developmental). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. Trust: 13%; England: 4%.

- Standard 4 (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. Trust: 96%; England: 73%.

The trust performed similar to other trusts in the following two metrics:

- Standard 1b. All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of capillary refill time recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. Trust: 21%; England: 23%.

- Standard 3 (developmental). There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). Trust: 83%; England: 70%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural sedation in adults 2015/16

In the 2015/16 procedural sedation in adults audit, the trust did not meet the national standard (100%) in any of the metrics.

The trust performed worse than other trusts for the following five metrics:

- Standard 2: There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. Trust: 13%; England: 52%.

- Standard 3: Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. Trust: 44%; England: 90%.

- Standard 4: Procedural sedation requires the presence of all of the below:
  - Standard 4a. A doctor as sedationist
  - Standard 4b. A second doctor, ENP or ANP as procedurist
  - Standard 4c. A nurse

  Trust: 5%; England: 41%.

- Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. Trust: 5%; England: 41%.

- Standard 7: Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  - 7a Return to baseline level of consciousness
  - 7b Vital signs within normal limits for the patient
  - 7c Absence of respiratory compromise
  - 7d Absence of significant pain and discomfort
  - 7e Written advice on discharge for all patients

  Trust: 0%; England: 3%.

The trust performed similar to other trusts for the following two metrics:

- Standard 1: Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including a) ASA grading, b) Prediction of difficulty in airway management and c) pre-procedural fasting status. Trust: 6%; England: 8%.
Standard 5: Monitoring during procedural sedation must be documented to have included all of the below: a) non-invasive blood pressure b) Pulse oximetry, c) Capnography, d) ECG. Trust: 7%; England: 24%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit the trust did not meet the national standard in any of the metrics.

The trust performed worse than other trusts for the following metric:

- Standard 1 (fundamental): If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment. Trust: 89%; England: 100%.

The trust performed similar to other trusts for the following metric:

- Standard 2 (developmental): Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation. Trust: 4%; England: 2%.

(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within 7 days

From January 2017 and December 2017, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5% but consistently better than the England average.

The trust’s performance was generally stable over the 12 month period with performance peaking in June 2017 at 7.1%.

Unplanned re-attendance rate within 7 days - Wirral University Teaching Hospital NHS Foundation Trust

(Source: NHS Digital - A&E quality)
Competent staff

The matron was responsible for overseeing staff education and appraisals in the department. This was because the department did not have a practice educator. As a result, we had concerns that this role was not undertaken effectively due to capacity issues. However, the department had recruited a practice educator who was yet to start at the time of the inspection.

It was unclear whether staff had been formally assessed as being competent to undertake their roles. The trust had an induction and preceptorship plan for staff. Staff who had recently qualified were required to complete a variety of competencies over a 12 month period in line with trust policy. This included topics such as administering medicines and gaining intravenous access.

However, we saw limited amounts of documented evidence that this had been completed. We were informed that staff kept their own preceptorship books once they had been completed. The trust policy mandated that all completed training records should be returned to the education department for this to be recorded. We reviewed the training records that had been submitted to the education department, finding that this process had been completed on most occasions.

Other members of staff such as clinical support workers were also required to complete role specific competencies. This was important as they were able to undertake extended skills such as undertaking observations and diagnostics such as blood tests. We sampled competency folders for five clinical support workers, finding that formal assessments of competencies had been completed on only one occasion. In addition, we found that documented evidence of staff being signed off as competent by an assessor had not been provided to the trust wide practice education facilitators. This was important as this involved an assessor observing a member of staff undertaking each skill before being able to undertake the skill without supervision.

The department had planned to provide a clinical support worker 24 hours a day, seven days a week to work with patients who attended with mental health issues. We found that appropriate training had not been provided for them to complete this role and staff who we spoke with informed us that they did not always feel equipped to manage challenging situations that they sometimes faced.

Members of the management team informed us that three registered nurses who regularly worked in the children’s department were adult nurses who had achieved additional paediatric competencies. However, we did not see any documented evidence that this had been completed.

The management team had identified two members of staff to complete a train the trainer course so that they were able to deliver major incident training to all staff in the department. We were informed that although the staff had completed this, major incident training had not yet been started.

Nurse practitioners had access to a variety of training courses. For example, emergency nurse practitioners were required to complete minor injury courses and advanced nurse practitioners were given time for professional development every week. This included access to the medical teaching rota.

All nursing and medical staff were required to have an annual appraisal which gave them an opportunity to discuss their achievements and areas for improvement. Members of the band 7 senior nursing team were responsible for appraising all nursing staff and were each allocated a team of nurses of different grades. Staff that we spoke with were aware of who their team leaders were.

Members of medical staff were also required to have an annual appraisal.
Appraisal rates
From April 2017 to October 2017, 43% of staff within urgent and emergency care at Arrowe Park Hospital had received an appraisal compared to the trust’s target of 88%.
A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals completed</th>
<th>Eligible staff</th>
<th>Appraisal rate</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>18</td>
<td>32</td>
<td>56.3%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>37</td>
<td>93</td>
<td>39.3%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>18</td>
<td>46</td>
<td>39.1%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

However, the management team informed us that improvements had been made to the number of appraisals completed and provided the following information for February 2018;

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals completed</th>
<th>Eligible staff</th>
<th>Appraisal rate</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td></td>
<td>32</td>
<td>94%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>93</td>
<td></td>
<td>73%</td>
<td>No</td>
</tr>
</tbody>
</table>

Consultants informed us that they received regular programmed activities for learning and education. However, middle grade and junior doctors informed us that education opportunities were sometimes limited due to operational demand.

The trust had a central team who monitored clinical revalidation for all staff. Senior nurses in the department were confirmers for the nursing and midwifery council, meaning that they were able to confirm revalidation when needed.

Multidisciplinary working
Staff informed us that they had mixed working relationships with other staff groups within the hospital. This included staff from medical and surgical specialities as well as the children’s and young people’s team.

Staff from the department attended regular bed meetings throughout the day to discuss access and flow. We took time to attend one of these meetings, observing that members of the management team were not fully included in discussions and did not have a full opportunity to raise any concerns that they had about access and flow from the department. We saw that once an update about the emergency department had been given, they were asked to leave the meeting.

However, during the inspection we saw a positive example of staff in the department working well when dealing with an emergency scenario alongside members of staff from the paediatric team.

Members of the management team worked closely with a local ambulance trust. There was an ambulance liaison officer based in the department who supported access and flow. They worked closely with the management team and were able to redirect patients to neighbouring emergency departments if needed.
The department held regular monthly attender meetings with external organisations such as the local ambulance service and mental health teams. This was to develop strategies to avoid inappropriate attendances in the department.

The hospital employed substance misuse support workers who attended the department on a regular basis. There was evidence that staff from the department sought help and advice from external organisations such as homeless services when needed.

We spoke with members of the security team who were located in close proximity to the department. They informed us that they had a good relationship with members of staff in the emergency department.

**Seven-day services**

The emergency department was open 24 hours a day, seven days a week. The management team had planned for the department to be covered 24 hours a day by a minimum of a senior middle grade doctor.

Consultant cover was planned between 8am and midnight, seven days a week. In addition, there was a consultant on call through the out of hours period. Staff informed us that consultants were easy to contact out of hours and that there were no problems with them reviewing patients if needed.

Members of the children’s medical team were available for advice and to review patients 24 hours a day if needed. The department had access to a resident children’s middle grade doctor out of hours as well as a children’s consultant who was on call.

The trust had a service level agreement with a local mental health trust who provided a psychiatric liaison assessment service for adults 24 hours a day, seven days a week. However, a child and adolescent mental health service was only provided between Monday and Friday during normal working hours.

The trust provided 24 hour cover for emergency surgery. Referrals were made to a local hospital for patients who had suffered major trauma. This service was available 24 hours a day, seven days a week.

The department had access to a 24 hour, seven days a week primary percutaneous coronary intervention service which was provided by a local hospital (this is a procedure used to treat narrowed coronary arteries and can be used as an emergency intervention for patients who have had a heart attack).

There was also access to a stroke team who were available 24 hours a day, seven days a week. An on call service was provided outside of these hours so that patients requiring emergency treatment received this in a timely manner.

The hospital had access to a 24 hour, seven days a week radiology service which was available within close proximity to the department. This included the provision of x-ray and computerised tomography scanning facilities.

Magnetic resonance imaging was available between 9am and 5pm from Monday to Friday for urgent referrals. However, it was unclear what arrangements were in place for patients who required emergency access to this service.

The trust reported some gaps in pathology and ultrasound. These were readily available between 9am and 5pm from Monday to Friday, but were not always accessible outside of these hours.
Health promotion

Staff that we spoke with informed us that they were aware of how to access support for patients around promoting patient’s health if needed.

All staff were encouraged to have a flu vaccination to help reduce the spread of flu between staff and patients.

Advice leaflets about a variety of conditions and disorders were available at different points in the department such as the waiting room.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

There was a trust wide policy for consent, mental capacity and deprivation of liberty safeguards which was accessible to staff on the intranet.

Most staff had an understanding of and were able to describe the process for best interest decisions and mental capacity assessments. However, not all staff were aware of the difference between the Mental Capacity Act and the Mental Health Act.

We reviewed five records for patients who potentially lacked capacity, finding that on two occasions there was no documented evidence of a best interest decision or mental capacity assessment. Medical staff were responsible for completing mental capacity assessments. This was in line with trust policy.

Staff in the department informed us that the recording of best interest decisions and mental capacity assessments had not been standardised. On reviewing patient records, it was difficult to locate these decisions which meant that there was an increased risk of all patient information not being handed over fully if a patient was admitted to an inpatient area.

The department did not have a Mental Health Act Code of Practice readily available to support staff in making decisions regarding patients who had been detained under the Act. This was important as a room in the department was used regularly to manage patients who had been detained under the Mental Health Act.

Staff in the children’s department understood Gillick Competence. Gillick competence is a term used in medical law to decide whether a child under the age of 16 years old is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Staff that we spoke with also had knowledge of Deprivation of Liberty safeguards. This is when restraint or restrictions can be used in a person’s best interest to keep them safe.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that their Protecting Vulnerable People (PVP) courses contained modules relating to the Mental Capacity Act (MCA), Deprivation of Liberty safeguards (DoLS) and Mental Health Act training. Data on the individual modules within these courses was not provided.

The trust set a target of 95% for completion of protecting vulnerable people training.

The breakdown of protecting vulnerable people training completion from February 2018 for nursing staff in urgent and emergency care at the trust is shown below:
Is the service caring?

Compassionate care

We observed examples of staff treating patients in a kind and compassionate way despite the department being very busy during the inspection.

We observed most staff in the department taking time to introduce themselves to patients and relatives before providing care and treatment.

We also observed staff responding quickly to patients on most occasions if they were uncomfortable or were distressed. However, there were two occasions when we observed patients had to wait longer than expected for attention. This was because staff were busy looking after other patients.

Patients were treated with dignity and had their privacy maintained. The department had designed a designated area for patients to be transferred from ambulance trolleys to hospital beds so that their privacy was maintained during this process.

The resuscitation area of the department was accessible by using the main ambulance corridor. We observed one occasion when staff put a screen in between any members of the public who were using the corridor to protect the privacy of a patient who was brought into the resuscitation area.

Friends and Family test performance

The trust’s urgent and emergency care friends and family test performance (% recommended) was generally worse than the England average from December 2016 to July 2017. From August 2017 the trust’s performance was above the England average and consistently improved from 88.5% in August to 92.2% in November 2017.
A&E Friends and Family Test Performance - Wirral University Teaching Hospital NHS Foundation Trust

Emotional support

Patients and relatives informed us that staff were approachable, friendly and were easy to talk to. They felt that they were able to express any concerns or anxieties that they had.

We saw examples of staff taking time to reassure patients and relatives if needed. We observed staff being sensitive in their approach towards patients when addressing concerns that had been raised.

We saw another example of when staff provided high levels of emotional support and reassurance to family members of a patient who was managed in an emergency scenario. The patient remained in the department for a number of hours and we observed that members of staff took time to provide constant reassurance to the relatives during this period.

The department had introduced patient safety checklists which were mandated for all patients who were admitted to the department. Safety checklists were broken down to support staff to make regular assessments of patients and included nutrition, personal hygiene and pain relief. However, we reviewed a sample of ten patient records, finding that this had only been used appropriately on two occasions.

Understanding and involvement of patients and those close to them

Patients and relatives that we spoke with informed us that staff had taken time to explain about the care and treatment that they were receiving. However, this had not always been documented clearly in patient records. We found that this had not been documented in five out of 12 patient records that we sampled.

Emergency Department Survey 2016

The results of the CQC Emergency Department Survey 2016 showed that the trust scored similar to other trusts in 22 out of the 24 questions relevant to caring and better in two questions.
<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.3</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.4</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the</td>
<td>5.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Is the service responsive?

Service delivery to meet the needs of local people

Parts of the department had been recently redesigned and modernised to meet the demand that the service faced on a daily basis. This included the reception area and waiting room, triage, minor injuries and the resuscitation area.

The waiting area had been extended so that it was not overcrowded and designing the service in a way that promoted flow through the department. We observed that when the department was busy, there was adequate seating available for patients and relatives.

However, we noted that information about the length of waiting times was not displayed for patients and families to see.

There was a children’s area that had been separated for the main department and was open between 8am and 11pm from Sunday to Thursday as well as between 9am and midnight on a Friday and Saturday. This area was secure, bright and child friendly. Toys were available for children to play with while waiting and the walls had been designed with child friendly pictures.

Outside of these times, children had to wait in the main waiting area and were assessed and treated in the same area as adults. Staff informed us that this was inappropriate due to how busy the department was and the challenges that the department sometimes faced during out of hours periods.

The emergency department review unit had been designed to meet the mixed sex accommodation standard that had been introduced by the Department of Health. This standard was important as it protects patient privacy and dignity as much as possible and states that accommodation for males and females should be separate at all times, although this did not apply to all other areas of the department as emergency treatment was being provided.

However, we were not assured that all breaches of the mixed sex accommodation standard had been reported in line with trust policy. This was because on one occasion we saw males and females being managed in the same area of the department due to increased demand. There was no evidence that this incident had not been reported to the incident reporting system.

The department was easily accessible for patients who required assistance with mobility, including patients who required the use of a wheelchair.

There was access to relative’s rooms which were located within the department. These were comfortable areas in which relatives were able to wait while patients were being treated.
The resuscitation area of the department had been designed in a way that provided an open and bright space for patients and relatives. There was a room in the resuscitation area that had been designed for children. This room was separated away from other bays and had been developed to maintain the privacy of children and their families.

Patients and relatives had access to vending machines in the department. There was also access to coffee shops and a restaurant during the daytime.

**Meeting people’s individual needs**

The department used an electronic flagging system to alert staff of any individual needs that a patient may have. Examples of this were if a safeguarding concern had been raised during a previous attendance at the hospital.

There was a flagging system for patients who were living with dementia. This supported staff to identify this group of patients. We observed a shift handover, observing that the transfer of information about patients who were living with dementia was thorough.

The trust employed a dementia matron who was available between Monday and Friday, during normal working hours. Staff informed us that they were aware of how to seek advice if needed. In addition, a volunteer group had made colourful sleeves that were used for patients who became agitated during their stay in the department. These were useful for patients who had cannulas (small plastic tubes that are used to deliver liquid solutions directly into a vein) and were receiving intravenous treatment.

The trust also employed a learning disability nurse who was only available one day a week. Learning disability passports were not used in the department and staff did not have an awareness of these. This was important as learning disability passports provide important patient information, particularly about communication needs to support staff when providing care and treatment.

Staff informed us that they would try and manage patients with learning disabilities in appropriate areas of the department. We saw an example of a patient being transferred to the emergency department review unit as this was a quieter and more appropriate area of the department.

The department had developed a room that was used as a viewing room for families and loved ones of patients who had passed away. The room had two separate areas as well as tea and coffee making facilities.

The management team informed us that they had recently developed an agreement with a local children’s trust to use their mortuary and bereavement facilities for families and loved ones of children who had passed away. This was because they felt that the mortuary facilities at the trust were not of the standard required.

There were no link nurses in the department. Link nurses are important as they attend extra training so that they are able to provide support to staff in the department about specialist areas such as dementia care and learning disabilities. The management team had identified this as an area for improvement.

The department had access to a 24 hour telephone based translation service. Staff informed us if a translator was required to attend the department this could be facilitated.

Patient advice leaflets were available in waiting areas about different conditions. However, these were not readily available in different languages, although we were informed that these could be supplied if required.
Emergency Department Survey 2016

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Access and flow

Patient flow through the department was restricted on a daily basis due to pressures that other areas of the hospital currently faced. Members of the management team attended regular bed meetings to provide an update of how many patients in the department were requiring an inpatient bed.

We attended a bed management meeting, observing that members of the management team were not fully included in discussions and did not have a full opportunity to raise any concerns that they had about access and flow from the department.

The management team also informed us that beds throughout the trust only became available at set times per day. This meant that patients in the department faced extended waits on a regular basis as this system did not meet the unpredictable demand that the department faced.

We also had concerns that managers and shift co-ordinators did not have the capacity to manage access and flow effectively through the department. This was because there was only one co-ordinator on duty at any one time and they were regularly included in the staffing numbers as a result of staffing shortages.

Staff informed us that they had mixed working relationships with other staff groups within the hospital. The management team had recently worked with staff in other areas of the hospital to develop a set of standards to promote shared responsibility of all staff in improving access and flow.

The department had access to the emergency department review unit which was used for patients who were receiving short term intervention, waiting for diagnostic results or for a discharge package to be put in place. Its purpose was to relieve pressure on other areas of the department. However, the unit was not always used in a way that promoted access and flow through the department. This was because a large number of incidents had been reported when the unit was used to care for patients who were waiting for an inpatient bed.

There was a clear inclusion and exclusion criteria for staff to follow when admitting patients to this area. We sampled the records of patients who were being cared for in this area during the inspection, finding that they met the inclusion criteria.

Records indicated that the monthly average length of stay in the emergency department review unit between April 2017 and March 2018 had ranged from 11 hours to 18 hours. We noted that
there had been a consistent increase in the average length of stay from November 2017 (14 hours) and March 2018 (18 hours).

There was access to a walk in centre as well as general practitioner services which were managed by another trust but were based on site. These services were available between 8am and 10pm, seven days a week. Patients were redirected from the emergency department when appropriate. This was done following a full initial assessment by a member of triage staff.

However, we were informed that there were challenges faced in using this service fully. This was because although patients were streamed using an agreed triage system, a high number of patients were asked to return to the emergency department.

In addition, the department had a streaming process to a minor injuries area which was staffed by nurse practitioners. Access to medical staff was also available in this area if required. The minor injuries area supported access and flow through the department as patients could be seen and treated without any further admission.

However, when reviewing staff rotas for March 2018, we found that there had been a number of occasions when this area had not been staffed appropriately. This meant that there was an increased risk of patients not always being seen in a timely manner.
Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the department.

The trust had continually struggled to meet this standard between January 2017 and December 2017.

From January 2017 to December 2017 the trust performed consistently worse than the England average. Although performance improved from September 2017 to November 2017 the percentage of patients waiting less than four hours was still below the England average. Performance declined again in December 2017.

Four hour target performance - Wirral University Teaching Hospital NHS Foundation Trust

![Graph showing four hour target performance]

(Source: NHS England - A&E waiting times)

The senior management team informed us that the figures reported to NHS England were combined figures for the emergency department and the walk in centre that was based on the same site, although this was run by a different trust. We were also informed that this method of reporting had been agreed by external stakeholders.

This meant that the performance of the emergency department alone were worse than the figures reported to NHS England. For example, in September 2017, records indicated that performance was 83% rather than 87% and in December 2017, performance was 70% rather than 78%.

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted

From January 2017 to December 2017 Wirral University Teaching Hospital NHS Foundation Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was worse than the England average.
Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - Wirral University Teaching Hospital NHS Foundation Trust

(Source: NHS England - A&E waiting times)

Over the 12 months from January 2017 to December 2017, an average of 693 patients per month waited over four hours from decision to admit until being admitted.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients over four hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-17</td>
<td>819</td>
</tr>
<tr>
<td>Feb-17</td>
<td>716</td>
</tr>
<tr>
<td>Mar-17</td>
<td>754</td>
</tr>
<tr>
<td>Apr-17</td>
<td>759</td>
</tr>
<tr>
<td>May-17</td>
<td>785</td>
</tr>
<tr>
<td>Jun-17</td>
<td>710</td>
</tr>
<tr>
<td>Jul-17</td>
<td>775</td>
</tr>
<tr>
<td>Aug-17</td>
<td>845</td>
</tr>
<tr>
<td>Sep-17</td>
<td>491</td>
</tr>
<tr>
<td>Oct-17</td>
<td>609</td>
</tr>
<tr>
<td>Nov-17</td>
<td>427</td>
</tr>
<tr>
<td>Dec-17</td>
<td>622</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E waiting times)

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Records indicated that between January 2017 and December 2017, the department had reported that patients had waited more than 12 hours from the decision to admit until being admitted on only one occasion.

We found that patients were spending longer than 12 hours in the department, although they were not officially recorded as having breached this standard. During the inspection we saw 18 incidences when the time spent in the department varied between 12 hours and 15 hours.

NHS guidelines state ‘the time of decision to admit is defined as the time when a clinician decides and records a decision to admit the patient or the time when treatment that must be carried out in
the accident and emergency department before admission is complete – whichever is the later’.

The trust policy indicated that only clinicians from the speciality that patients were referred to had admitting rights. This was important as it meant that the decision to admit time was not officially recorded at the point that medical staff from the emergency department deemed patients to be fit for admission. The delay between the time documented by a member of medical staff from the emergency department and from the accepting speciality varied between one and three hours. We observed this on a number of occasions during the inspection.

**Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment**

From January 2017 to July 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse than the England average. From August 2017 performance improved with the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment being better than the England average from September 2017 to November 2017. However, performance deteriorated again in December 2017.

**Percentage of patient that left the trust without being seen - Wirral University Teaching Hospital NHS Foundation Trust**

![Graph showing percentage of patients leaving the trust without being seen](image_url)

(Source: NHS Digital - A&E quality indicators)

**Median total time in A&E per patient (all patients)**

From January 2017 to December 2017 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. Although performance against this metric showed an improvement from August 2017 to November 2017 it was still above the England average and the performance deteriorated again in December 2017.
Learning from complaints and concerns

The trust had a complaints policy which was located on the intranet for staff to access if needed. The complaints policy outlined the expected time periods for a complaint to be acknowledged and closed.

All formal complaints were co-ordinated by a central complaints team. They allocated complaints to the relevant management team for investigation.

Staff we spoke with informed us that if a complaint or a concern was raised, they would escalate it to the person in charge of the department. The management team were aware of how to access information for patients and relatives when needed.

The trust had also introduced a matron’s hotline. This initiative had been introduced to provide a direct contact for patients who wanted to make a complaint or raise a concern. The trust had reported an overall reduction in formal complaints since this had been introduced.

We also noted that the department had not made complaints leaflets available for patients and relatives to access.

Summary of complaints

From November 2016 to November 2017, there were 50 formal complaints about urgent and emergency care. At the time the data was provided, 37 of the complaints had been closed and the trust took 68.8 days to investigate and close these closed complaints.

The trust has not provided details of the level of the complaints. Their complaints policy states that level 2 complaints should be closed within 25 days; level 3 complaints within 45 days; and complex level 4 complaints in 60 days.

The themes from the 50 complaints were:

- Patient care – 21 complaints
- Communications – 10 complaints
- Admissions and discharges (excluding delayed discharge due to absence of care package) - eight complaints
- Appointments – six complaints
- Prescribing – two complaints
- Restraint – two complaints
- Patient slip trip or fall – one complaint
We reviewed a random sample of eight formal complaints that had been made between November 2016 and November 2017, finding that there was evidence that all had been acknowledged within three days, however, none had been closed within the time period stated in the policy. In addition, there was no evidence that the patients or families involved had been notified that there was going to be a delay in finalising the outcome of the investigation.

Advice was provided for patients and relatives who were dissatisfied with the outcome of a complaints process. In these incidences they are able to contact the parliamentary health service ombudsman. The ombudsman is an independent adjudicator who considers complaints when departments within the National Health Service have not acted properly, fairly or have provided a poor service.

Records indicated that between November 2016 and November 2017, 12 complaints had been partially upheld following investigation. This meant that the management team had identified areas of improvement that were required.

It was unclear how improvements were being made from complaints. This was because we reviewed minutes of departmental meetings between March 2017 and February 2018, finding that there was no documented evidence that complaints had been discussed. We also reviewed minutes of divisional meetings for the same period, finding that complaints were a standing item on each agenda. However, there was no evidence of discussion about complaints or actions implemented to make improvements.

Is the service well-led?

Leadership

The trust had redesigned the leadership structure for the division of medicine in November 2017. The division was led by a divisional director, an associate director of nursing as well as an associate medical director. During the restructure, an additional associate director of nursing had been employed to provide leadership to acute care within the division. This involved the emergency department. The trust also employed a head of urgent care who managed a number of other areas in the trust as well as the emergency department.

We had concerns that there were insufficient numbers of leaders in the emergency department to carry out their roles effectively. This was because the matron for acute care had responsibilities for several areas in the trust. In addition, the department did not have a practice educator at the time of the inspection and the trust had not employed a department manager.

The department had identified a clinical lead who had been in post six months and there was also a clinical lead for paediatrics who had sub speciality training for children. This met the Royal College of Emergency Medicine standard and was important as approximately 25,000 children had attended the department in the last 12 months.

The management team were supported by a team of band 7 co-ordinators who had been planned to remain supernumerary on every shift in order to co-ordinate access and flow as well as to maintain patient safety. However, we noted that shift co-ordinators had been included in staffing numbers (to look after patients) on a regular basis due to staffing shortages.

Managers did not always have access to training which allowed them to complete their roles effectively. For example, a consultant in the department had taken the responsibility of leading governance and risk. We were informed that no extra training had been provided to support them to undertake this role. In addition, shift co-ordinators had not been supported to attend a formal
leadership training course, although there was an action to improve this in the improvement plan for the department.

Staff in the department informed us that members of the departmental leadership team were visible, approachable and supportive. However, staff informed us that senior managers were not visible, particularly at times of increased pressure.

Vision and strategy

The trust had an overall vision and strategy. The management team were able to identify with this. However, other staff in the department were unsure of what the trust vision and strategy was.

The division of medicine had developed a strategy which outlined six key priorities between 2017 and 2019. However, it was unclear how these priorities were going to be achieved. It was also clear who had ownership of these and how they were going to be reviewed to assess how much progress had been made.

An improvement plan for the emergency department had been implemented in January 2018. Prior to this, the department had not had a formal plan to make improvements in the department.

The improvement plan had been developed by the divisional and departmental management team. Actions included improving patient flow, improving compliance with training, to introduce link nurses in the department and to introduce clinical supervision for all nursing staff. We saw that a small number of actions had already been completed.

However, it was unclear if staff of different grades had been involved in developing the plan and we were unsure how the action plan was being monitored. This was because we reviewed minutes of governance meetings for the division of medicine and the emergency department, finding that the improvement plan had not been included on the agenda and had not been discussed on any occasion.

In addition, we were provided with two different versions of the improvement plan. This meant that it was unclear if all members of the management team were aware of which improvement plan was being used.

There was a trust wide patient flow action plan that identified actions for both the division of medicine and the emergency department. Each action had an owner and a date for completion. However, we noted that there were only a small number of actions that involved the emergency department and that the majority were for the division of medicine overall.

Culture

Staff who we spoke with indicated that they had not always felt valued by members of the management team. Some staff who we spoke with also informed us that they had witnessed or experienced bullying and harassment. Information we reviewed also indicated that there had not always been a positive culture across all staffing groups within the department.

A large number of staff informed us that when issues had been raised with the divisional and executive team, they had received no acknowledgement of their concerns and that no actions had been taken. We had concerns about this as some of the issues raised were related to patient safety.

We also had concerns about the role that members of staff from the department played in the wider organisation. For example, we attended a bed management meeting, finding that once the member of staff who attended had given an update, they were actively dismissed from the
meeting, meaning that they were unable to contribute or have an understanding of the issues that the wider trust faced.

Staff had access to the freedom to speak up guardian. This was important as it provided staff a forum to raise concerns that they had confidentially. However, we found that when concerns had been raised, appropriate action had not been taken by the management team in the division to investigate and resolve them in a timely manner. As a result, concerns had been escalated to the executive team by the freedom to speak up guardian.

We saw evidence that a cultural review of the department had recently been commissioned by the executive team. The report from this had been finalised at the time of inspection although the action plan to make improvements was still in draft format. We had concerns that the action plan had been developed without input from members of the departmental leadership team and that the draft action plan did not cover all issues that had been identified within the cultural review.

We did note that some staff in the department felt supported and were proud of their role. For example, we spoke with a number of staff who had recently started working in the department. They informed us that although their job was challenging, they enjoyed working in the department. Staff were committed in wanting to provide the best patient care possible.

**Governance**

The trust had a governance structure which allowed information to be shared from ward to board level. However, we found that the governance structure for the emergency department and the division of medicine had not always been effective.

We found that monthly departmental clinical governance meetings had not always been held. Between April 2017 and March 2018, meetings had been cancelled on five occasions. This meant there was an increased risk that important information had not been reviewed or discussed during these periods. More importantly it was unclear how risks had been managed and improvements had been made in a timely way.

We reviewed minutes of meetings that had taken place during this period, finding that there were set agenda items including mortality reviews, risk management as well as patient safety and improvements. There was evidence that all identified actions had owners and that any outstanding actions were reviewed as part of each meeting. However, there were no time periods for actions to be completed by.

Departmental governance meetings were led by members of medical staff. We found that other members of the leadership team had not attended all meetings.

We reviewed agenda items for the divisional meeting which included complaints, risks and best practice guidelines. However, identified actions from the meeting were unclear and no time periods for actions to be completed in had been identified. This meant that there was an increased risk that actions would not be completed in a timely manner.

Minutes of meetings indicated that members of the leadership team from the emergency department had attended divisional governance meetings on most occasions.

The division held monthly meetings for the senior nursing team. However, we reviewed minutes from three of these meetings, finding that there was no representation from the emergency department in any of them.

There were no clear arrangements for the management of service level agreements that the division of medicine or the emergency department had with external organisations. For example,
the trust had a service level agreement with a local mental health trust who reviewed patients with mental health issues following referrals being made from the emergency department. We saw no evidence of the performance against the service level agreement being monitored in any of the minutes of meetings that we reviewed.

A member of medical staff from the department had attended and contributed to ongoing meetings of the local crisis care concordat forum. The mental health crisis care concordat was a national agreement between services and agencies involved in the care and support of people in mental health crisis. It set out how organisations would work together better to make sure that people get the help they need when they were having a mental health crisis.

Management of risk, issues and performance

The trust had a risk management strategy which was available to all staff on the intranet. This strategy outlined how risks within each department should be managed.

There was a risk register for the emergency department which highlighted a number of risks that the department currently faced. Managers were able to identify with what was on the risk register and were able to tell us what the top three risks were. All members of the management team informed us that patient flow, staffing and patient safety were the main challenges that were faced by the department.

We reviewed all risks for the emergency department, finding that they had been scored, had an owner and had a date when they were due for review. Each risk had been broken down to identify areas where controls could be implemented and there was an action tracker to monitor the progress against each action.

However, there were a number of risks that had been kept on the risk register since 2012 and it was unclear if these remained as a risk to the department. There was no evidence that these had been reviewed in either departmental or divisional governance meetings. In addition, all actions had not always been completed in a timely manner. For example, overcrowding in the department had been identified as a risk in May 2017. We noted that there was no record of completed actions against this risk, although an owner had been identified.

In addition, we were not assured that effective controls had been implemented to manage a small number of risks that had been identified. For example, a risk of safeguarding processes for children not being followed out of hours had been identified. Although all staff had received safeguarding level 3 for children, there were no actions implemented to manage the inconsistent completion of mandated safeguarding questions. We identified this as an issue during the inspection.

A small number of risks for the department had also been escalated to the corporate risk register as they were also risks that were faced in other areas of the trust. An example of this was the inability to achieve planned staffing levels.

A number of risk assessments had been completed for the department, including manual handling as well as violence and aggression. We reviewed six of these, finding that none had been reviewed in line with trust policy. This was important as health and safety risk assessments demonstrate that controls have been implemented to reduce the risk of harm to patients, relatives and staff.

When areas requiring improvement had been identified it was not always clear what systems had been put in place to monitor improvements on a regular basis and make further improvements.
when required. We were also uncertain if the management team were receiving the correct level of assurance against areas of concern.

The matron conducted a walk around once per month. This was used to monitor compliance against a number of areas including the use of modified early warning scores and whether call bells had been given to patients appropriately. However, the sample size of records reviewed was small. For example, only five observations had been made during March 2018 to make sure that patients were identifiable through the use of a wristband.

A revised matron’s audit had been introduced in January 2018 to provide more assurance against areas of concern such as the failure to complete patient safety checklists or risk assessments appropriately. These had been identified as areas of non-compliance between January and March 2018 and we also found these to be issues during the inspection. It was unclear if any action had been taken to make improvements in these areas before the inspection.

The trust had implemented a system to monitor whether staff were compliant with the procedures that had been put in place for all staff in the department to follow when transferring a patient’s care from the emergency department to an inpatient area of the hospital. Although daily audits of this showed continual poor compliance, we did not see any evidence of actions put in place to make any improvements.

The management team had put some controls in place to reduce the risk of patient harm, particularly during busy periods. For example, a clear inclusion and exclusion criteria had been developed for different areas of the department and standard operating procedures had been developed to support staff. In addition, an overcrowding policy had been developed to support the department at times of increased pressure, although this was in draft format at the time of inspection.

**Information management**

Dashboards were available to measure compliance with key performance indicators such as all patients receiving an initial assessment within 15 minutes of arrival. We saw evidence that although this information was submitted to external stakeholders, it was not regularly reviewed during meetings that had been held by the departmental or divisional management teams.

We had concerns that some data collated by the trust was not always accurate. For example, information given about mandatory training was not recorded properly and different versions of the improvement plan being submitted for the department. This meant that we were not assured that managers had access to the correct and most up to date information.

In addition, the trust was unable to provide us with all the information that we requested. For example, we did not receive assurances that staff had the appropriate levels of advanced paediatric life support, not only in the department but across the trust.

We found that a large amount of information was received in some meetings. However, it was not always clear from minutes of meetings what happened to this information and how it had been used to make improvements. There was no documented evidence of discussion or challenge in regard to this information.

Staff had access to electronic patient records in the department. This was on a different system to the electronic records system used in the rest of the hospital. Information could be accessed across the two systems. However, we found that some information could not be transferred. An example of this was patient observations and modified early warning scores that had been completed in the emergency department.
Staff informed us that they had access to information that was needed for them to undertake their roles effectively. They had access to policies and procedures on the intranet. In addition, they were able to access a number of patient pathways, protocols and risk assessments which could be added to patient records when needed.

There were electronic systems in place which included a flagging system which was used to identify the individual needs of patients or highlight any safeguarding or infection control concerns.

**Engagement**

All staff were asked to complete an annual staff survey. We reviewed results from 2017 for the overall trust, finding that the response rate had only been 31%. This was below the national average of 45%. In addition, results that had been broken down to acute and medical services (which included the emergency department) indicated that 65% of staff felt that they were able to contribute to making improvements. Also, only 19% of staff who took part felt that there was effective communication from the management team.

Additionally, we reviewed monthly temperature checks that had been undertaken in the department between September 2017 and February 2018. Records indicated that the response rate had varied between 11% and 14% during this period. Results for staff recommending the department as a place of care varied between 87% and 92% during the same period.

The trust held listening into action events. Records indicated that these had been held annually. This allowed staff to raise any concerns. Staff felt that they had been listened to but informed us that they had not always received feedback from these events.

The trust also held ‘PROUD’ awards annually. This was an opportunity to reward staff from all areas of the hospital for their hard work and achievements. Records indicated that staff from the emergency department had won an award in 2016.

The trust also sought feedback from patients and relatives through the friends and family test. Results showed that between July 2016 and June 2017, the trust performed worse than the England average when patients and relatives were asked if they would recommend the trust as a place of care.

We did not see any evidence of the department using any other methods to seek feedback from patients and relatives in order to inform areas where improvements could be made.

**Learning, continuous improvement and innovation**

The management team demonstrated a ‘no blame culture’ in regard to encouraging staff to report incidents. They acknowledged that there had been challenges with encouraging staff to report all clinical and non-clinical incidents.

Incidents were discussed when clinical governance meetings had taken place, at both departmental and divisional level. The trust produced a ‘safety bites’ bulletin which had been designed to disseminate learning to staff throughout the hospital. In addition, the departmental management team had introduced a monthly governance newsletter to disseminate learning from incidents and to inform staff of any changes or issues.

However, we were not assured that learning from serious incidents had always taken place. This was because we saw evidence that some serious incidents had been closed before a full investigation had taken place. This was not in line with the NHS Serious England Framework 2015.
The department made regular data submissions to the Royal College of Emergency Medicine which allowed patient outcomes to be benchmarked nationally. However, we were not assured that sufficient actions had been implemented to make improvements where needed. This was because we reviewed three action plans, finding only one to have any actions documented in order to make improvements to areas of non compliance.

For example, an action plan was developed following poor compliance against recording vital signs in children. The action plan stated that ‘repeat observations would be done in a timely manner as a new electronic system had been introduced’. There was no evidence of any further actions implemented to make improvements and the management team had not completed a further audit to measure if improvements had been made.

Members of the management team worked closely with external providers such as a local ambulance service to manage daily pressures that the department faced. In addition, collaborative working had also been facilitated with the local accident and emergency delivery board.
Acute services

Medical care (including older people’s care)

Facts and data about this service

The medical care service at Arrowe Park Hospital has 394 inpatient beds.

The trust had 51,148 medical admissions from October 2016 and September 2017. Emergency admissions accounted for 26,231 (51.3%), 2,727 (5.3%) were elective, and the remaining 22,190 (43.4%) were day case.

Admissions for the top three medical specialties were:

- Gastroenterology: 10,285
- General medicine: 9,467
- Geriatric medicine: 9,327

(Source: Hospital Episode Statistics)

The ‘acute and medical’ division manage medical services. There are a number of wards including general medical and specialist services including stroke services, cardiology, respiratory, haematology, nephrology, cardiac care unit, endoscopy, dialysis unit and care of the elderly. Wards 27 and 21 are specialist dementia care wards.
During the inspection we visited ward 14 (escalation area), ward 12 (surgical/medical ward), ward 19 (escalation), ward 21 (male dementia), ward 22 (geriatric medicine), ward 23 (stroke unit), ward 24 (geriatric medicine), ward 25 (isolation unit), ward 27 (female dementia) ward 32 (cardiology), ward 36 (gastroenterology), ward 37 (respiratory care) and ward 38 (respiratory care). We also visited the cardiac care unit, endoscopy department, day case unit, ambulatory care unit, acute medical unit, medical short stay ward and discharge hospitality centre.

We spoke with 62 members of staff including senior managers, members of the patient experience team, ward sisters as well as registered nurses and doctors and clinical support workers. We also spoke to 18 patients and relatives.

We observed care and treatment and looked at 40 patient care records and 17 medicine administration records as well as service performance data.

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 ensured that staff completed it. However, there was significant difference in the data the service provided on mandatory training before and during the inspection.

Before the inspection the trust provided us with the data on compliance below.

Mandatory training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

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

A breakdown of compliance for mandatory courses from April to October 2017 for nursing staff in medical care at Arrowe Park Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion %</th>
<th>Trust Target</th>
<th>Target met</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
The overall completion rate for mandatory training modules by nursing staff in medical care at Arrowe Park Hospital was 26.4%. Nursing staff did not meet the trust target for any of the seven mandatory training modules.

A breakdown of compliance for mandatory courses from April to October 2017 for medical staff in medical care at Arrowe Park Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion %</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td>50</td>
<td>132</td>
<td>37.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block B</td>
<td>49</td>
<td>132</td>
<td>37.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block A</td>
<td>42</td>
<td>132</td>
<td>31.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety Level 2</td>
<td>15</td>
<td>88</td>
<td>17.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>2</td>
<td>28</td>
<td>7.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security 1</td>
<td>9</td>
<td>132</td>
<td>6.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management Level 2</td>
<td>4</td>
<td>96</td>
<td>4.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Please note that Block A contains Manual Handling, Health & Safety Level 1, Risk Management Level 1, Consent Awareness, End of Life Care and Moving & Handling modules. Block B contains Fire Safety, Infection Prevention & Control and Medicines Management modules.

The overall completion rate for mandatory training modules by medical staff in medical care at Arrowe Park hospital was 23.1%. Medical staff did not meet the trust target for any of the seven mandatory training modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff accessed mandatory training online and face-to-face. We viewed electronic staff records that recorded mandatory training compliance for staff by each module. We viewed mandatory training records for three staff that showed completion rates of 47.1%, 85.7% and 100%. This showed an inconsistency in compliance rates across staff. Some were completing training and other staff had not completed all the modules.

The learning and development department produced monthly mandatory training reports for each
ward. We viewed reports for February 2018 for wards 21, 22, 23, 27 and 32 for safeguarding level 2 and equality and diversity training. No ward was compliant with the trust target for equality and diversity training.

The service provided updated data on compliance with mandatory training as shown below.

<table>
<thead>
<tr>
<th>Mandatory Training Compliance 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>Jan-17</td>
</tr>
<tr>
<td>Feb-17</td>
</tr>
<tr>
<td>Mar-17</td>
</tr>
<tr>
<td>Apr-17</td>
</tr>
<tr>
<td>May-17</td>
</tr>
<tr>
<td>Jun-17</td>
</tr>
<tr>
<td>Jul-17</td>
</tr>
<tr>
<td>Aug-17</td>
</tr>
<tr>
<td>Sep-17</td>
</tr>
<tr>
<td>Oct-17</td>
</tr>
<tr>
<td>Nov-17</td>
</tr>
<tr>
<td>Dec-17</td>
</tr>
</tbody>
</table>

There was an inconsistency in senior staff’s understanding of mandatory training compliance rates. Senior staff informed us that mandatory training was not up to date in many areas due to staffing shortages, sickness and vacancy rates. Ward sisters informed us that they received an email alert every four months to inform them of staff training needs. They also stated that mandatory training was not up to date for all staff. However, the data provided by the trust shows compliance is nearly at target for block A training.

Staff received training in sepsis management and the sepsis ‘red card’. Staff informed us that on ward 24, 100% of staff were trained.

**Safeguarding**

Staff understood how to protect patients from abuse and the service did not always work with other agencies to do so. Staff had training on how to recognise and report abuse but training compliance rates were below the trust target.

Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to and staff knew how to access them. They were up to date and contained all the necessary information required to support staff to recognise safeguarding concerns and how to respond appropriately.

Staff we spoke with were able to explain how they would respond to a safeguarding concern and knew how to access information.

Safeguarding training was available for staff but the compliance rate was below the trust target.
for both nursing and medical staff. The service had ‘protecting vulnerable people’ training which included safeguarding adults, safeguarding children, PREVENT, Mental Capacity Act, Deprivation of Liberty Standards, domestic violence, Mental Health Act and dementia awareness. The service provided updated data on compliance with safeguarding training targets as shown below.

Before the inspection the trust provided the following data on safeguarding training compliance.

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust reported that their Protecting Vulnerable People (PVP) courses contain safeguarding adults and children modules. Data on the individual modules within these courses was not provided.

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

A breakdown of compliance for safeguarding courses from April to October 2017 for nursing staff in medical care at Arrowe Park Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion %</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>276</td>
<td>344</td>
<td>80.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 3</td>
<td>116</td>
<td>203</td>
<td>57.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

*Please note that the trust informed us that their PVP courses contain modules relating to Safeguarding Adults, Safeguarding Children, PREVENT, Mental Capacity Act, Deprivation of Liberty Standards, Domestic Violence, MHA and Dementia Awareness.*

The overall completion rate for the two PVP modules by nursing staff in medical care at Arrowe Park Hospital was 71.7%. Nursing staff did not meet the trust target for either module.

The breakdown of PVP training completion for medical and dental staff in medical care from April to October 2017 at Arrowe Park Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Sum of Trained (YTD)</th>
<th>Sum of Eligible (YTD)</th>
<th>Sum of Completion rate YTD</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>36</td>
<td>93</td>
<td>38.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 3</td>
<td>14</td>
<td>39</td>
<td>35.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for the two PVP modules by medical staff in medical care at Arrowe Park Hospital was 37.9%. Medical staff did not meet the trust target for either module.

*(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*
Following the inspection the trust provided us with the following information.

| Protecting Vulnerable People Compliance 2017 |
|----------------|----------------|
| Month | Level 2 | Level 3 |
| Jan-17 | 18.60% | 3.67% |
| Feb-17 | 23.85% | 14.09% |
| Mar-17 | 28.69% | 22.58% |
| Apr-17 | 34.58% | 29.49% |
| May-17 | 40.94% | 38.32% |
| Jun-17 | 50.40% | 45.02% |
| Jul-17 | 60.41% | 55.50% |
| Aug-17 | 65.13% | 64.42% |
| Sep-17 | 74.73% | 70.28% |
| Oct-17 | 74.69% | 77.63% |
| Nov-17 | 75.46% | 78.47% |
| Dec-17 | 76.39% | 77.99% |

Though still below trust target this demonstrates a continued improvement in compliance since January 2017.

The trust had a standard operating procedure relating to female genital mutilation (FGM) that worked in conjunction with the Wirral FGM Multi Agency Protocol 2015. Staff received training in safeguarding women and children from female genital mutilation as part of mandatory training.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. However, staff did not always consistently keep equipment and the premises clean. They used control measures to prevent the spread of infection in some areas.

Some areas did not complete daily cleaning checklists. We reviewed cleaning schedules for March 2018 on ward 36 and saw that there was no cleaning checklist for bay two and bay four was only completed on 7 March 2018. The acute medical unit had gaps in daily cleaning checklist in bays one through to seven for several days in March. In some areas, we saw fabric curtains and there was no schedule to change and clean these. In the discharge hospitality centre, we observed a strong smell of urine and the dirty utility room was unlocked and accessible from the bedded area.

We found suction equipment stored on the floor on wards 37 and 38 that was visibly dusty. The area around the resuscitation trolley in acute medical unit was visibly dusty and cluttered with suction equipment on the floor.

The day case unit accommodated medical inpatients and we observed that the bays did not have doors. Staff told us that patients with infectious illnesses had used the beds. We reviewed incident reports and saw that in January 2018 patients with flu had been treated in the same bay as
patients without the infection. Staff had also reported they had not been able to follow infection control procedures for patients with diarrhoea due to the environment.

Staff told us that on more than one occasion patients were transferred onto a ward after a flu swab but prior to results being confirmed. Staff managed this by applying infection control procedures to the whole bay.

However, overall wards appeared visibly clean. Staff used ‘I am clean’ stickers to indicate equipment had been cleaned. The isolation ward carried out a ‘commode handover’ at each shift change which ensured that nurses identified the commodes which needed cleaning and those clean and ready to use were clearly identified with a ‘I am clean’ sticker. We observed staff used aprons and wet-dry wipes at meal times.

Staff washed hands before and after providing care or treatment using the World Health Organisation five moments for hand hygiene. We observed that staff followed ‘bare below the elbows’ guidance. Alcohol hand gel was available on entrances and exits of wards and at each bed space and staff and visitors used these to reduce the spread of infection.

Personal protective equipment was available for staff at the entrance of side rooms and bays. We observed staff using personal protective equipment when delivering care and treatment to patients.

We observed the processes in place for decontamination of equipment used in invasive procedures in endoscopy. This was carried out in a way that minimised the risk of infection to patients and was in line with national guidance.

The medicine division had monthly infection control meetings that identified issues pertinent to infection control and actions to address issues.

The service carried out an annual audit of infection prevention and control measures. Audits were overdue on wards 19, 27, 31 and 36 and on the coronary care unit, day case unit and discharge hospitality centre. Areas we looked at in this inspection had reached silver or gold standard on the annual environmental audit of infection control procedures apart from medical short stay unit, which scored 67% and those that had overdue audits. We reviewed the infection control environmental audit scores provided by the service and saw that ward 24, older person’s assessment unit and acute medical unit had improvement plans in place.

The service audited infection control cases by ward and division on a monthly basis. Each area audited water safety and flu positive results on a weekly basis and carried out monthly hand hygiene audits. Water safety checks were carried out weekly in all areas. However, medical short stay unit did not carry out any water safety checks between 29 January 2018 and 19 February 2018.

We saw that electronic patient records contained infection control flags for patients with specific flu types and contained an appropriate and completed pathway for a patient with meticillin-resistant staphylococcus aureus. Wards displayed annual infection control audits and staff reported that bays were closed to prevent spread of flu. On the specialist isolation ward staff carried out a ‘commode handover’ to assure themselves of cleaning and hygiene standards. We observed the environment team providing extra cleaning on a ward that accommodated flu patients.
Environment and equipment

The service did not have suitable premises and equipment in all areas and did not always look after them well.

In some areas we found sluice rooms unlocked and they contained cleaning fluids, chlorine dioxide, detergent, flying insect killer spray, toilet cleanser and descaler. Care of substances hazardous to health risk assessments had been completed for these products and safety sheets were available. Health and safety best practice guidance on the storage of substances hazardous to health is that they are kept in a secure cupboard or store room. We saw this on wards 21, 25, 36 and 37, in the acute medical unit and discharge hospitality centre. We found one sluice room on ward 21 opposite a bay was also unlocked with scissors and a 24-hour urine sample accessible as well as cleaning fluids. The bay accommodated patients with dementia and at the time of our observation no staff member was present. This meant there was a risk that patients and the public had access to hazardous substances.

During our inspection, we found unlocked store cupboards that contained syringes and needles. Sharps boxes did not have the partial closure mechanism in use.

On ward 21 three Actimel drinks stored in a patient fridge were out of date. We told the nurse in charge who immediately removed them.

In some areas we found Digi locks on the sluice room, records room, cleaning store and clean utility and equipment was appropriately and securely stored.

We found one oxygen cylinder with an illegible date for portable appliance testing and another that was overdue for portable appliance testing. In the discharge hospitality centre two oxygen cylinders were not secured to the wall; we informed staff during our inspection who arranged to have them removed. Health and safety best practice guidance is that oxygen cylinders should be stored securely in a well ventilated storage area or compound when not in use.

We found a suction machine on ward 12 where the portable appliance test was due in February 2018.

Resuscitation trolleys were stored in accordance with Resuscitation Council (UK) guidelines with resuscitation drugs stored in tamper-evident containers. Daily checks were completed, however on ward 37 the emergency trolley checklist was missing checks for seven days in February. Some emergency trolleys were dusty and on ambulatory care unit the defibrillator portable appliance test was due in February 2018 and had not been carried out.

The day case unit accommodated medical inpatients; staff reported they borrowed moving and handling equipment from the pre-operative assessment unit. There was one patient toilet designated for single sex use, staff told us male patients used a commode. Staff informed us that the shower was out of use and patients washed using bowls by their bedside. We reviewed incident reports for the day case unit from December 2017 to March 2018 and found that staff had reported lack of suitable equipment and environment on eight separate occasions.
We saw that on the isolation ward staff could not observe patients without entering the room and following full infection control measures due to the position of doors and glass panels on rooms. The issue was escalated to the trust risk register and an action plan to submit costs for improvement works had been developed.

The discharge hospitality centre provided comfortable chairs and a commode and crutches were available for patient use. However, it had mixed sex toilets that were also used by physiotherapy patients. There was an office behind a screened area in the corner of the bedded area. This office was not used for staff in the discharge hospitality centre but by staff from another department. Equipment was stored in the reminiscence corner, which was cluttered and could not be easily used. Equipment was also stored in one of the bed bays.

We found that the hoist in the discharge hospitality centre was out of use. Staff informed us that if needed they borrowed a hoist from older persons assessment unit.

Pressure relieving mattresses and cushions were used for patients with pressure ulcers and staff reported that extra mattresses and cushions could be requested if needed. On the stroke unit staff carried out skin assessments within six hours and patients were given heel boots and leg elevation where appropriate. However, staff informed us that the ambulatory care unit did not always have pressure relieving equipment for chairs or trolleys.

The endoscopy unit provided an appropriate and secure environment. Staff used a secure swipe pass to access the department which was only accessible to authorised staff with a separate inpatient entrance. We saw that staff had access to gowns and exposure tags outside the x-ray room and the room had a clear ‘do not enter’ light.

The endoscopy unit was joint advisory group (JAG) accredited. JAG accreditation is awarded to high-quality gastrointestinal endoscopy services and meant the service had met all the environmental standards.

**Assessing and responding to patient risk**

The service planned for emergencies and staff understood their roles if one should happen. However, risks to patients were not consistently assessed in all areas where care was being delivered to ensure their needs were being met.

The service told us that they completed risk assessments when opening escalation areas that identified an action plan for reviewing staffing levels. We saw that a risk assessment had been completed in January 2017 for opening ward 14. However, we could not find evidence of completed risk assessments for the day case unit and ward 19. The service told us that that they had not completed a risk assessment for the opening of this ward as an escalation area as they considered this a planned opening.

We found that patient acuity was not always taken into account when accommodating patients in escalated beds. Staff told us that escalation areas did not operate in line with the standard operating procedure as they admitted patients after 5pm and had admitted patients who were living with dementia. On ward 19 escalation area there were no substantive nurse staffing levels
assigned at night. Staff reported that moves of patients who were not medically optimised prior to transfer or who did not meet the criteria for the ward mostly happened after 5pm or at weekends when senior ward staff were not present.

Staff followed a procedure to monitor patients who were acutely unwell. On admission to the ward nurses completed a checklist that included pain assessment, skin condition assessment, malnutrition universal screening tool scores, falls assessment and pressure sore assessment. On respiratory wards specialist nurses carried out patient oxygen assessments.

The wards used national early warning system (NEWS) for adults for staff to recognise and escalate patients in a timely way if their condition was deteriorating and staff had received training in this. We examined 22 patient records where we looked to see that this tool was used appropriately. We saw that these were completed and staff had escalated appropriately where the score had indicated a medical review. We observed discussion of patient national early warning system scores as part of handover.

Staff understood how to escalate sepsis appropriately in accordance with the policy. We were told sepsis trolleys were available on the wards which contained the necessary sepsis equipment. On ward 24 we saw an example of a national early warning system score where staff had escalated the patient through the sepsis pathway within the hour. On this ward we observed a sepsis trolley which was stocked with the appropriate sepsis equipment, and was in date. We were told that 100% of registered nurses had received the sepsis training and the ward had no sepsis related incidents reported.

Of the 22 patient records which we reviewed two had been identified as potential sepsis and we observed that these had been escalated appropriately in line with the trust policy. However, on ward 25 staff had not repeated observations following a national early warning system score of 3 in a timely manner.

We reviewed the sepsis audit action plan provided by the trust and saw that a number of actions have been implemented to improve performance on sepsis recognition and treatment. Staff used the ‘red card’ system to escalate sepsis patients. The ‘red card’ system was an adult sepsis screening and action tool which staff used with all patients who were clearly unwell and displaying unusual symptoms. The tool and pathway was based on the red flag sepsis tool developed by the UK Sepsis Trust. Staff reported that treatment of patients was prompt and they were able to escalate concerns appropriately. Sepsis equipment was available on wards and registered nursing staff were trained in sepsis and the ‘red card’ system.

Ward 36 had a protocol for escalation of gastrointestinal bleeds and followed National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations for the management of gastrointestinal bleeds.

All 22 patient records contained pressure ulcer assessments and 21 contained VTE assessments. VTE stands for venous thromboembolism and is a condition where a blood clot forms in a vein. We also looked at records for 10 patients on ward 36 and saw that the VTE risk assessment had been completed for all the patients we looked at. The outcome was unclear for one patient and the pharmacist was aware of this and would follow this up as part of their clinical multi-disciplinary team role.
Four of the 22 patient records we reviewed did not contain completed nutritional risk assessments.

All 22 patient records we examined contained completed falls risk assessments. One matron had specific responsibility for falls prevention. Wards had introduced the use of sensor pads and commode tagging and had access to assistive technology for patients assessed at high risk of falls. Staff told us that the patient falls assessment is repeated when a patient transfers to another ward. We saw on ward 23 a new initiative in place which was called ‘answer the call before the fall’, with this we saw the use of a basic visual assessment. The ‘answer the call before the fall’ initiative was an awareness campaign to encourage staff to answer call bells as soon as possible to prevent avoidable falls. This was because many falls were reported as the patient had attempted to walk to the toilet themselves after using the call bell which had not been answered. We saw posters on display on the ward and staff reported since the introduction of the initiative there had been a reduction in falls from eight incidents in January 2018 to four in March 2018.

Wards 21, 22, 23 and 27 had implemented a ‘red slipper sock’ initiative. Patients assessed as at high risk of having a fall wore red non slip socks so all staff could quickly and easily identify such patients and quickly offer assistance. Staff we spoke to knew about the initiative and how to respond to a patient in red socks. Ward 27 was a pilot ward for a falls prevention initiative and had developed a ‘ten key questions for visual assessment’ tool with an optician. Staff informed us that care of the elderly wards had regular falls safety huddles.

During our inspection we observed that following a patient fall staff reviewed the falls assessment and instigated red slipper socks. However, staff had not completed an incident report; we highlighted this to the senior nurse.

Staff in acute medical unit told us that the number of patient falls had increased in the last two months. However, the service had introduced measures to prevent falls following an incident including additional falls risk training for staff. The matron responsible for falls prevention told us that three training sessions had been held and the service would organise more.

The trust had a medical emergency team to respond when a patient deteriorated. This was a team of medics and was also supported by the critical care outreach team which consisted of nurses. There was a deteriorating patient and modified national early warning scores (mNEWS) policy that outlined the core members of the medical emergency team. The service monitored the number of calls to the team and the number of patients they were called to. We reviewed data provided by the service and saw that the number of calls to the team had increased significantly since September 2017 when the service introduced the use of mNEWS. In August 2017 there were 148 calls to the team this rose to 292 in September and was 368 in March 2018. The service reported that this had a positive impact on the number of admissions, referrals to intensive care and cardiac arrests. However, at the time of our inspection the service had not audited the impact of this and had only been collecting data since September 2017 which had not been analysed.

Nurse staffing
The service did not always have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The service planned and reviewed staffing levels and skill mix. However, safe staffing levels were not consistently maintained and staff worked without breaks. This remained an issue since the last inspection.

During this inspection we found that planned and actual staffing levels on staffing boards at each ward displayed gaps in registered nurse staffing. Safety boards on ward 12 and ward 23 displayed the ratio of staff hours filled in February 2018 as 76% and 94% respectively. The board on ward 38 showed that on that day they had planned versus actual staffing of six planned registered nurses for morning shift with an actual of five, for the afternoon shift five planned registered nurses versus four actual and for the night shift four planned registered nurses versus three actual.

Staff told us that registered nurses were moved to cover other areas even if their ward was not fully staffed. Staff stated that they did not feel staffing levels were safe and we saw that they reported this using the trust incident reporting process. We examined incident reports for the period March to September 2017 and saw that the service reported 233 incidents relating to lack of staff. We reviewed incident records that demonstrated staff were working without breaks and had reported concerns about safe care and treatment due to low staffing levels.

The cardiac care unit had a planned staffing ratio of two registered nurses for seven patients. During our inspection we saw that on cardiac care unit one registered nurse had to travel with a patient during transport to another provider leaving staffing of one registered nurse, one clinical support worker and one consultant for seven patients. The unit maintained safe staffing in this area by the ward sister providing cover until a clinical support worker was moved from the main cardiology ward. On the cardiology ward one registered staff nurse was responsible for 12 monitors.

We reviewed staffing records for the 19 to 28 February 2018 for ward 32 cardiology and saw that on the 19 February three day shifts and one night shift were not filled by registered nurses, with one day shift covered by a bank registered nurse. On 20 February, three days shifts and one night shift were not filled by registered nurses, with one night shift covered by an agency registered nurse. This meant that the service did not meet its own plans for the number of registered nurses on duty on those dates.

We reviewed the staffing figures for the medical wards between July and November 2017 and found there were a number of wards where the number of shifts filled as planned was below 80%.

<table>
<thead>
<tr>
<th>Date</th>
<th>Ward</th>
<th>Day fill rate below 80% – registered nurses</th>
<th>Night fill rate below 80% – registered nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 17</td>
<td>12</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OPAU (older people's assessment unit)</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>33 (winter ward)</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MSSW (medical short stay ward)</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24 (IPC)</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>August 17</td>
<td>12</td>
<td>73%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OPAU</td>
<td>79%</td>
<td></td>
</tr>
</tbody>
</table>
The trust provided updated fill rates based on care contact hours for November 2017 to February 2018. Care contact hours are an assessment of care needed for the acuity and dependency of the patients on the ward. We found there were a number of wards where the planned care hours did not meet the required level.

<table>
<thead>
<tr>
<th>Date</th>
<th>Ward</th>
<th>Day fill rate below 80% – registered nurses</th>
<th>Night fill rate below 80% – registered nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2017</td>
<td>OPAU (older people’s assessment unit)</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>27</td>
<td>75.5%</td>
<td>71.6%</td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>76.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>33 (winter)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>38 and LAU</td>
<td>68.5%</td>
<td>69.5%</td>
</tr>
<tr>
<td></td>
<td>MSSW (medical short stay ward)</td>
<td>72.7%</td>
<td>79.7%</td>
</tr>
<tr>
<td></td>
<td>24 (IPC)</td>
<td>67.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>49.5%</td>
<td>50%</td>
</tr>
<tr>
<td>October 2017</td>
<td>OPAU (older people’s assessment unit)</td>
<td>76.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>77.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>27</td>
<td>75.5%</td>
<td>74.2%</td>
</tr>
<tr>
<td></td>
<td>MSSW</td>
<td>71.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24 (IPC)</td>
<td>60.4%</td>
<td>67.7%</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>52.5%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>37</td>
<td>69.4%</td>
<td>56.5%</td>
</tr>
<tr>
<td>November 2017</td>
<td>MSSW</td>
<td>66.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>54.9%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>24 (IPC)</td>
<td>58.3%</td>
<td>66.7%</td>
</tr>
<tr>
<td></td>
<td>37</td>
<td>56.7%</td>
<td>51.7%</td>
</tr>
</tbody>
</table>
We reviewed incidents reports from March to September 2017 relating to lack of appropriate and qualified staff. We found 18 incidents relating to acute medical unit which demonstrated an impact on patient care including delays in patient focussed observations, delays to pressure ulcer care, admission assessments not done within the six hour guideline, delays in administering medication and not completing daily cleaning checklists. On the 3 April 2017 a patient with severe sepsis on acute medical unit waited 45 minutes for an assessment.

Wards in the medical division reported nursing vacancies, with cardiology the highest with eight and a half whole time equivalent vacancies. We saw that the trust managed this by including ward sisters in staffing levels rather than as supernumerary staffing. The Royal College of Nursing recommends that ward sisters are supernumerary to allow them to be visible to staff, patients and visitors, to monitor and evaluate standards of care, to provide feedback and to innovate and implement change. Staff informed us that ward 19 did not have any substantive registered nursing staff at night, and the ward sister was included in the substantive staffing levels during the day shift.

The service reviewed nurse staffing levels on each area through a daily matron led staffing meeting, looking at planned staffing levels versus actual. Nurse staffing numbers were rated (red, amber and green) to determine if they met the required number and staffing numbers for the day and the next 24 hours were recorded. The service planned staffing for the next two days and identified options to fill short fall such as contacting the bank or offering staff additional shifts. We saw emails that confirmed that the bank had been approached to fill shifts. We reviewed the records of these meetings and found there were a number of occasions when wards had been rated as amber. For example on 22 March 2018 there were 56% of medical wards rated as amber and on 23 March 2018, 71% were rated as amber.

The service had 70 whole time equivalent nurse vacancies. The service was actively recruiting to nurse vacancies. The trust quality dashboard reported that 81 vacancies were advertised in December 2017 and 105 advertised in January 2018. Plans to address vacancy rates included rotating critical care nurses to cardiology for six months at a higher band and promoting nurses to band six to improve retention rates. However, staff reported that the centralised vacancy control process was slow and caused delays.
The trust reported the following nurse staffing numbers for medical care at Arrowe Park Hospital in March and October 2017. The service had establishment rates of over 90% in both time periods.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Actual WTE Staff in post</th>
<th>Planned WTE Staff in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>481.0</td>
<td>516.5</td>
</tr>
<tr>
<td>October 2017</td>
<td>494.1</td>
<td>531.4</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

The following nurse staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Vacancy rates

From November 2016 to October 2017, Arrowe Park Hospital reported a vacancy rate of 6.3% for nursing staff in medical care. The trust did not provide a vacancy target rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From November 2016 to October 2017, Arrowe Park Hospital reported a turnover rate of 13.6% for nursing staff in medical care; this was over three times higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From November 2016 to October 2017 Arrowe Park Hospital reported a sickness rate of 4.3% for nursing staff in medical care which is slightly higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

From November 2016 to October 2017, Arrowe Park Hospital reported 9,039 shifts filled by bank staff (5.1%) and 429 shifts filled by agency staff (0.2%) in medical care. There were 7,406 shifts not filled by bank or agency staff (4.2%).

A breakdown of bank and agency usage by staff type is shown below:

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>6,974 (9.4%)</td>
<td>2,065 (2.0%)</td>
<td>9,039 (5.1%)</td>
</tr>
<tr>
<td>Agency</td>
<td>0 (0.0%)</td>
<td>429 (0.4%)</td>
<td>429 (0.2%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>2,848 (3.8%)</td>
<td>4,558 (4.5%)</td>
<td>7,406 (4.2%)</td>
</tr>
</tbody>
</table>
The areas with the highest bank or agency use were ward 36, ward 32 and acute medical unit.

Senior nursing staff told us that it was difficult to fill nursing shifts through the bank (NHSP) and sometimes they were given very short notice of a shift being filled. We reviewed incidents reports relating to lack of staffing from March to September 2017 and found 13 recorded incidents of bank staff being requested but not found. We reviewed the integrated quality governance report from March 2018 which demonstrated that in November 2017 the fill rate for bank shifts was 59% a decreased from October 2017 (68%).

The service provided data for the period 1 November 2016 to 31 October 2017 on the number of nursing and clinical support worker shifts not filled by the bank. This data supported the staff’s assertion that nursing shifts were more difficult to fill than clinical support worker shifts. Acute medical unit had the highest number of unfilled nursing shifts at 897. Cardiology (ward 32) had 394 shifts unfilled by bank nursing staff and ward 38 had 597 unfilled. On the acute medical unit and the infection control ward over 10% of nursing bank or agency shifts available were not filled.

Staff we spoke with told us that often agency and bank nurses were not trained in the electronic patient record system so they could not carry out the full duties required of a registered nurse. This put additional pressure on the nursing staff on the wards.

During our inspection we observed nurse led handovers on two wards. Handovers included the patients’ current presentation, national early warning system scores, referral to other teams, discharge plans, patient mobility and background information on the patient’s social situation. Wards held ‘huddles’ following the handover which included an update on safety issues and any outstanding observations needed.

**Medical staffing**

The trust reported the following medical and dental staffing numbers for medical care at Arrowe Park Hospital in March and October 2017. The service had an establishment rate of 73.5% (March 2017) and 70.0% in the latest period.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Actual WTE Staff in post</th>
<th>Planned WTE Staff in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>133.9</td>
<td>182.1</td>
</tr>
<tr>
<td>October 2017</td>
<td>129.2</td>
<td>184.6</td>
</tr>
</tbody>
</table>

(The source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

The following medical and dental staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
Vacancy rates

From November 2016 to October 2017, Arrowe Park Hospital reported a vacancy rate of 31.0% in medical care for medical and dental staff. The trust did not provide a vacancy target rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From November 2016 to October 2017, Arrowe Park Hospital reported a turnover rate of 11.3% for medical and dental staff in medical care; this was nearly three times higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From November 2016 to October 2017, Arrowe Park Hospital reported a sickness rate of 0.1% for medical and dental staff in medical care which is lower than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

From November 2016 to October 2017, Arrowe Park Hospital reported 2,708 shifts filled by bank staff and 1,103 shifts filled by locum staff in medical care. There were 48 shifts not filled by bank or locum staff.

A breakdown of bank and locum usage by staff type is shown below. Please note that the trust did not provide the total shifts available for middle grade doctors so we are unable to calculate bank and locum usage overall or for this staff type as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Consultant</th>
<th>Middle grade</th>
<th>Doctor in training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>357</td>
<td>92</td>
<td>2,259</td>
<td>2,708</td>
</tr>
<tr>
<td>Locum</td>
<td>699</td>
<td>127</td>
<td>267</td>
<td>1,103</td>
</tr>
<tr>
<td>Not filled</td>
<td>28</td>
<td>8</td>
<td>10</td>
<td>47</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staff informed us of concerns regarding consultant staffing levels we were told that four consultants had resigned. Acute medical unit had consultant vacancies. The service was using locum cover as proposals to cover the vacancies were still in development. Medical staff told us that it was common for annual leave and absence not to be covered and there were incidents where only one doctor had been on call overnight or for four hours. They told us they felt that patient safety had been affected by lack of medical staff. We reviewed 13 staffing incidents reported between April 2017 and March 2018 relating to lack of medical cover. We saw that there had been five occasions on the acute medical unit where there was insufficient or no junior doctor
cover. We viewed a report which told us that 14 patients on acute medical unit had waited over 12 hours for a medical review due high volume of patients and only two junior doctors being on shift. Wards 21, 22, 30 and 38 had also reported incidents of low or no medical cover.

Ward 25 did not have a dedicated consultant as all patients were considered as outliers. Outliers are patients who are not on the correct speciality ward. Staff told us that they had difficulty accessing consultants for patient review and this affected consistency of care. Staff told us they felt this had contributed to an incident the month before the inspection. The trust had managed this by recruiting a junior doctor for ward 25. We reviewed eight sets of patient records and found two had no consultant review and for the other six reviews had taken place between two and five days after admission to the ward. Outliers should receive a senior medical review each day.

Cardiology had a consultant of the week system in place with one consultant leading the ward rounds for a whole week. Staff reported that this had improved continuity of care.

**Staffing skill mix**

As from October 2017, the proportions of consultant and junior (foundation year 1-2) staff reported to be working in medical care were higher than the England averages.

**Staffing skill mix for the 170 whole time equivalent staff working in medicine at Wirral University Teaching Hospital NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>44%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>17%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>34%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 year’s 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 (01/10/2017 - 31/10/2017)*
Records

Staff kept appropriate records of patients’ care and treatment but these were not always stored securely. Records were clear and up-to-date but not available to all staff providing care.

The service used an electronic patient record system and staff told us they had received training in this system. During our inspection we reviewed 22 electronic patient records and found that they were contemporaneous, comprehensive and accurate. However, we saw that some paper records were still used and these were not always stored securely. Also some staff were not able to explain to us how to use the electronic patient record.

Electronic patient records did not contain previous paper records leading to a dual system. All endoscopy records were paper but the report from the endoscope was on a different electronic system than the electronic patient record system.

On ward 12 we saw that a paper record was kept for patient ‘rounding’. Patient ‘rounding’ is a process of regular nursing checks to ensure patient’s fundamental care needs are being met. Staff told us that they kept paper records because bank staff did not all have access to the electronic patient record.

Staff used both desk top computers and portable hand held devices to access records. We saw computer screens that were not locked and left unattended clearly displaying confidential patient information.

We observed a board on display in the discharge hospitality centre which was fully visible to the patients and public who may be collecting a patient. This contained patient name, first half of postcode and provider responsible for transporting patient home.

We also found that case notes trolleys were left unsecured on wards 19, 21, 22, 25, acute medical unit, medical short stay ward, ambulatory care unit and cardiac care unit. We saw that case notes had been left on top of a desk in medical short stay unit. Therefore non-authorised staff, patients and visitors could access confidential patient records.

Staff reported that agency and bank registered nurses were not all trained in the electronic record system, which meant they could not access all the information needed to deliver safe care and treatment in a timely and accessible way.

Electronic patient records contained appropriate details of patient needs and treatment including a care plan and evidence of daily ward round reviews. Where it was applicable, we saw evidence of discussion with family members.

All paper records we reviewed were signed and dated.

In the endoscopy department we reviewed four patient records where the patient assessment prior to treatment had been fully completed and signed by a registered nurse. We observed that patient case notes including referral notes and wristbands were prepared prior to treatment and available to staff in the endoscopy department as the patients’ arrived.
Medicines

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

During this inspection the specialist pharmacy inspector spoke to three members of staff, one student nurse, one nurse (mentor) and one pharmacist.

We visited a ward with 38 patients and reviewed 10 of the medication administration records. The ward had a clinical pharmacist attached and all of the patient's records we looked at had medicines reconciliation completed. The pharmacist showed us the process for completing this and use of the pharmacy notes on the electronic medical record to ensure hand over of information. There was a good prioritisation of patients to ensure the medicines reconciliation could be completed within 24 hours.

Antimicrobial Stewardship was reviewed. Six out of the 10 records we looked at had antibiotics prescribed. Five out of the six had a stop date. The indication was not always clear on the prescription however the pharmacist was able to show us the microbiology section of the notes to clarify for each patient why the antibiotic was prescribed. The electronic medical record system had recently been updated to include an antimicrobial stewardship section and we were told this would support the prescribing module to include indication in the future. Staff told us that the pharmacist attended the weekly microbiology ward round.

The discharge hospitality centre did not have a ward location on the electronic system; staff showed us how they retrieved a patient's medication administration record. The discharge hospitality centre was co-located with a satellite pharmacy unit and we were told that medication doses could be administered if required.

We looked at the storage of medicines on ward 36. The main treatment room had a pharmacy information board clearly stating who the ward pharmacist and technician were and how to contact them. It contained locked cupboards that were secure, however not all of the medication had been put away in these cupboards. The temperature in the treatment room on ward 36 was 28.4C, this is above the recommended national guidance of 25C for room temperature. The treatment room temperature in the discharge hospitality centre was higher than the recommended 25C, after discussion with the nurse in charge a portable heater was relocated so it was not directly by the medication storage area.

Ward 36 had two fridges one for total parenteral nutrition and nutritional supplements and one fridge for medication. We found an out of date nutritional supplement, fortijuice expired 8 January 2018. We also found an out of date total parenteral nutrition, staff told us this was labelled for a patient who no longer required this; it had not been returned to pharmacy for destruction. The label stated do not use after 2 March 2018. The medication fridge was very full, this does not meet the national guidelines, there should be sufficient space between the fridge items to allow the air to circulate.

We also looked at the storage of medications, including controlled drugs on ward 38. We reviewed records of controlled drug checks from December 2017 to March 2018 and saw that these had been completed daily. Staff told us that medicine stock was checked daily by pharmacy. We saw
that oral and external medicines were stored separately. We checked seven different types of oral medication and saw that they were in date and matched the records in the stock record book. We reviewed room and fridge temperature monitoring for February 2018 and saw that this had been completed daily apart from four days and all temperatures were within expected range. Staff told us if fridge or room temperatures were outside of the expected range they reported this to the medicines housekeeper.

**Incidents**

Overall, the service managed patient safety incidents well. 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, though staff recognised incidents they did not consistently report all incidents. There were delays in reporting outcomes from incidents and developing action plans.

Staff told us that they reported incidents using the electronic reporting system and were able to give examples of using the reporting system appropriately. They told us they had reported incidents relating to staffing levels, medication errors, patient falls and inpatient beds being used overnight in ambulatory care unit. On the acute medical unit staff were able to describe the action taken following an incident report about a patient fall which included sharing the root cause analysis investigation in the team meeting and reviewing staff training needs.

We saw that ward 23 had developed an ‘answer the call before the fall’ initiative in response to eight falls reported in February 2018. The ‘answer the call before the fall’ initiative was an awareness campaign to encourage staff to answer call bells as soon as possible to prevent avoidable falls. Staff on wards 37 and 38 showed an awareness of incident reporting and the weekly safety summits. We observed a morning safety huddle on ward 19 which included the message of the week and reminder of a previous incident and action to be taken.

The service conducted monthly audits of safety huddles to ensure they covered feedback and learning from incidents. We reviewed records which showed that safety huddles had been observed on wards 21 and 22 every month since January 2017 apart from November and December 2017 on ward 21.

Staff could explain the principles of duty of candour and give an example of when these were applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person. They informed us that duty of candour meetings with patients or relatives were led by senior staff. The quality and safety lead for the division monitored the application of duty of candour. However, we had concerns that duty of candour had not always been applied when needed as managers told us that they would only apply duty of candour if a root cause analysis had been completed. This was not in line with the regulatory requirement which states that it should be applied for all notifiable patient safety incidents that had resulted in a moderate level of harm or above.

The trust held weekly safety summit meetings which any member of staff could attend. It then produced a weekly ‘safety bytes’ electronic bulletin highlighting key lessons to all staff. We
observed a safety summit and reviewed the following safety bytes bulletin and found that it accurately summarised the learning points from the summit meeting.

The service held monthly falls group meetings attended by all ward sisters. All root cause analysis investigation outcomes relating to patient falls was discussed at this meeting. A monthly divisional effectiveness group also met which included a discussion of root cause analysis investigations. We reviewed agendas for January 2018 and March 2018 and saw that they included serious and untoward incidents as an agenda item.

Senior leaders in the service demonstrated an awareness of incidents reported. They described an ongoing investigation regarding ‘boarding’ patient where it was felt this impacted on patient safety. They informed us they examined all incident reports coded moderate or above and they were discussed at the trust serious incident panel.

However, we also found that staff did not always report all incidents relating to staffing levels. Staff told us that when they did report concerns regarding staffing levels using the incident report system they did not always receive feedback. Staff told us that they had not received feedback on a patient fall incident which they had reported which caused serious harm. They also told us that when they had submitted 21 incident reports in one weekend they had not received any feedback from management.

The service provided information on incidents reported between October 2017 and April 2018. We reviewed this information and saw that of 1660 incident records 113 had no outcome description completed so no action plan or outcome was recorded. The number of incidents in the service which were in the web holding file for over 20 days increased by 328 in January 2018. This means there was a delay in reporting outcomes and developing action plans related to these incidents.

Staff also told us that they were unable to attend safety summit meetings due to low staffing levels on the ward. Some staff reported that they were not able to attend team meetings or safety huddles due to their shift patterns. However, staff had access to minutes from meetings in the staff room. Staff also reported they were not able to attend mortality and morbidity meetings due to low staffing levels on the ward.

During our inspection we saw a patient fall which required an incident report to be completed. However, when we reviewed this we saw that no report had been submitted. We raised this with the nurse in charge for further investigation.

**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 January 2017 to December 2017, the trust reported no incidents classified as never events for medicine.

*Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017)*
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 65 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from January 2017 to December 2017. Of these, the most common types of incident reported were;

- Slips/trips/falls meeting SI criteria with 42 (64.6% of total incidents).
- Abuse/alleged abuse of adult patient by staff with five (7.7% of total incidents).
- Pressure ulcer meeting SI criteria with four (6.2% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with three (4.6% of total incidents).
- VTE meeting SI criteria with three (4.6% of total incidents).
- Medication incident meeting SI criteria with three (4.6% of total incidents)

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

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

We saw that safety thermometer data was displayed on boards within the wards. The wards displayed data in infection control audit results, complaints, falls, pressure ulcers, meticillin-resistant staphylococcus aureus, clostridium difficile and escherichia coli.

The safety board on ward 23 was updated each month and showed that it had been seven days since the last patient fall and ten days since the last pressure ulcer.

Staff on ward 27 explained that the ‘safer’ board highlighted safety issues which were then discussed in the morning huddle which could last up to 45 minutes. We observed that the board included up to date information on hospital acquired pressure ulcers, patient falls with harm, deprivation of liberty safeguards, oxygen levels and catheters. The board indicated that the last patient fall with harm on the ward was 157 days ago.

Staff told us that they monitored the safety thermometer information on a monthly basis and we saw an updated safety board within the matrons’ office which displayed data for each ward. We reviewed the integrated quality governance report for March 2018 and found that the number of falls on ward 23, the stroke unit, had decreased between December and February 2018. In December 2017 there were nine falls, in January 2018 there were eight falls and in February 2018 there were two falls. Staff told us that the ward had been focusing on falls prevention work. However, some staff reported that though they submitted monthly safety thermometer data they did not receive feedback on performance.

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 16 new pressure ulcers, 13 falls with harm and 10 new urinary tract infections in patients with a catheter from December 2016 to December 2017 for medical services. The incidence of pressure ulcers is particularly high in the latter months (November and December 2017).

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Wirral University Teaching Hospital NHS Foundation Trust**

- **Total Pressure ulcers**
  - (16)

- **Total Falls**
  - (13)

- **Total CUTIs**
  - (10)

(Source: Safety thermometer - Safety Thermometer)

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and they had policies and procedures which reflected this. The trust had a ‘clinical audit forward plan 2017/2018’ which was approved and overseen by the clinical governance group, this included a combination of national and internal audits.

The trust managed sepsis through a sepsis pathway and the policy was in line with The National Institute for Health and Care Excellence guidance. Staff used an electronic national early warning scores system to screen patients and identify sepsis. The trust had appointed a matron for deteriorating patients who provided sepsis and critical care outreach. We were told that the
deteriorating patient matron had provided sepsis training to ward staff and a sepsis ‘red card’ system was in place.

The service had an endoscopy department which was accredited by the Joint Advisory Group (JAG) on gastro intestinal endoscopy. The accreditation had been renewed in January 2018 and demonstrates that the service is working in line with guidance and JAG professional standards.

The trust had a protocol in place for the risk assessment and prophylaxis for venous thromboembolism, which met the national institute of care excellence guidance. However, the trust provided audit data which told us that they were not yet compliant with the National Institute for Health and Care Excellence guidance for undertaking the venous thromboembolism risk assessment within 24 hours of admission.

**Nutrition and Hydration**

Staff gave patients enough food and drink, however they did not always provide them with assistance at meal times to meet their needs and improve their health.

Staff assessed patient’s nutritional needs on admission as part of the nursing assessment checklist on the electronic patient record system. The checklist included physical and cultural needs. Staff made assessments of nutritional needs following the malnutrition universal screening tool and the trust policy outlined the escalation process for this. Staff told us they were aware of how to escalate appropriately in accordance with trust policy and referrals were made electronically.

We reviewed 22 patients records across four wards and identified that on two occasions the nutritional assessment had not been undertaken. The first occasion was because weighing scales were not available, which had been documented on the patients record. The second occasion the patients had been admitted for 17 days and there was no reason documented for the assessment not being undertaken. We saw a mixed adherence to the policy for escalating malnutrition universal screening scores. In 22 records we observed two occasions where appropriate escalation had taken place and one occasion where a patient had triggered escalation but no referral had been made to the dieticians.

The trusts quarterly point prevalence audit for nutrition and hydration showed in October 2017 only 60% compliance with the requirement for weekly assessment using the malnutrition universal screening tool. This was a decline in the results from the previous audit. We were told the trust board has acknowledged that current performance needed to be improved and that improvement plans were being developed. However, none were in place at the time of the inspection.

The wards had nutritional status boards which detailed patient’s nutritional needs and choices against their bed number. Examples of diet needs displayed were diabetic, soft and pureed food. During meal times we observed meals being provided in pureed and soft forms. We were told there was a meal co-ordinator on each shift. Staff told us that patients who were identified as needing assistance with eating were helped by staff or relatives. Staff also told us they observed the patients they are looking after and ensured they assisted those who may need it. During our observations of meal times across three wards we identified eight patients who were struggling to eat their meals and were not given assistance by the ward staff. We saw these patients trays of food being taken away with large quantities of food left on them. We saw an additional two patients who were helped to eat by visiting relatives.

Patients had a choice of menu, at lunchtime soup and a choice of sandwiches were available and the evening meal was a hot meal. We observed lunchtime and saw patients being offered a choice
of sandwiches, however there was no choice of soup. We observed a patient telling staff they did not like the lunchtime options and the staff member contacted the kitchens to seek alternative options. Different coloured trays were in use to support patients to eat who had additional needs. 

Water was available on patient’s tables and hot drinks were offered at meal times. Patients reported that swallowing difficulties were not always communicated to the care support workers who gave out the drinks. We were told they had been given drinks in formats they could not tolerate.

**Pain relief**

Patients pain was monitored and recorded regularly. The service assessed patients pain on admission using the nursing assessment checklist and pain scores were used. Intentional rounding was undertaken which included regular assessment of pain.

We saw in some areas this was recorded electronically and in other areas paper based systems were in use. Pain relief was available and patients did not identify access to pain relief as an issue. Patient group directives were in place for nursing staff so that paracetamol could be administered to patients requiring simple pain relief in the absence of a doctor to prescribe it.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and had positive results against the national average. Patient outcomes were reviewed in divisional operational management team meetings, clinical governance meetings as well as mortality and morbidity meetings. An internal audit programme was in place and the trust contributed to national clinical audits.

The acute medicine service contributed to the society for acute medicine benchmarking audit and staff told us they were rated third in the area on this audit for 2017.

**Relative risk of readmission**

**Trust level**

From September 2016 to August 2017, the overall expected risk of readmission for both elective admissions and non-elective admissions was generally similar to the England average aside from:

- Patients in Gastroenterology had a higher than expected risk of readmission for elective admissions while patients in Clinical Haematology and Nephrology had lower than expected risks of readmission.

- Patients in General and Respiratory Medicine had lower than expected risks of readmission for non-elective admissions while the risk of readmission for patients in Geriatric Medicine was higher than expected.

**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 is represents the opposite. Top three specialties for specific trust based on count of activity.

**Non-Elective Admissions – Trust Level**

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

**Arrowe Park Hospital**

From September 2016 to August 2017, for patients at Arrowe Park Hospital, the overall expected risks of readmission for both elective admissions and non-elective admissions was generally similar to the England averages.

- Patients in Gastroenterology had a higher than expected risk of readmission for elective admissions while patients in Clinical Haematology and Nephrology had lower than expected risks of readmission.

- Patients in General and Respiratory Medicine had lower than expected risks of readmission for non-elective admissions while the risk of readmission for patients in Geriatric Medicine was higher than expected.

**Elective Admissions - Arrowe Park 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 trust based on count of activity.

Non-Elective Admissions - Arrowe Park Hospital

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

Sentinel Stroke National Audit Programme (SSNAP)

Arrowe Park Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved an overall SSNAP level of grade A in latest two audits, for the time periods January to March 2017 and April to June 2017.

Arrowe Park Hospital

<table>
<thead>
<tr>
<th>Team-centred KI levels</th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Scanning</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>2) Stroke unit¹</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>3) Thrombolysis</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>4) Specialist Assessments</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>5) Occupational therapy</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>6) Physiotherapy</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>7) Speech and Language therapy</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>8) MDT working</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

¹ Source: HES - Readmissions (01/09/2016 - 31/08/2017)
We were told the lower rating of C rating for speech and language therapy was due to delayed complex assessments. This was attributed to short staffing within the team. The trust had identified this as an area of concern and we saw it recorded on the risk register.

**Heart Failure Audit**

**In-hospital Care Scores**

Results for Arrowe Park Hospital in the 2015 Heart Failure Audit were like the England and Wales average for all four of the standards relating to in-hospital care:
Discharge Scores

Results for Arrowe Park Hospital were better than the England and Wales average for all seven standards relating to discharge:

![Discharge Scores Chart]

(Source: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015))

National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 79 inpatients with diabetes at Wirral University Teaching Hospital, 78.1% of which reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile one. The trust’s performance was lower than the England average of 83.7%.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as
opposed to trust).

At Arrowe Park Hospital 62.9% of nSTEMI patients were admitted to a cardiac unit or ward in 2015/16 and 95.5% were seen by a cardiologist or member of the team compared to an England averages of 55.8% and 96.2%, respectively.

The proportion of nSTEMI patients who were referred for or had angiography at Arrowe Park Hospital was 87.8% compared to an England average of 83.6%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 82%, which was worse than the audit minimum standard of 90%. The 2015 figure was 90%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 27.8%; this is not significantly different from the national level. The 2015 figure was 33%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 62.1%; this is not significantly different from the national level. The 2015 figure was 62%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 82.1%; this is not significantly different from the national level. The 2015 figure was 65%.

The one year relative survival rate for the trust in 2016 was 40.5%; this is not significantly different from the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

Arrowe Park Hospital has a multi-disciplinary working group for falls prevention where data on falls are discussed at most or all the meetings.

None of the patients had a vision assessment; the national aspirational standard is 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment was 38%; this is below the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium was 14%; this is well below the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 71%; this was below the national aspirational standard of 100%.

(Source: Royal College of Physicians)
The service had identified that falls were an area of concern and this was on the trusts risk register. There was a falls initiative in place on the wards we visited. This involved the use of red non slip, slipper socks. We were told that they were given to patients identified at risk of a fall following the falls risk assessment. Staff told us this helped them identify patients easily who may be walking unaided and require immediate assistance and to prevent slips for those at risk.

We checked 22 patient records across four wards and saw that falls risk assessments had been completed, and we saw care plans in place for those identified at risk of a fall. We saw assisted technology in place for patients at risk of falls who may be likely to wander, these were alarmed sensor pads. Staff told us the use of bed rails was also in place to prevent falls and we were told where they were in use daily assessments were completed.

Some areas reported an increase in patient falls which they had linked to staffing pressures, this was a concern in acute medicine.

**Competent staff**

The service made sure that staff were competent for their roles.

New starters were given a structured induction programme. The induction programme for registered nurses included a four day in house clinical skills training course and four week supervision period. Newly qualified nurses were supported through the preceptorship programme. Healthcare support workers completed an in-house core skills training programme and the national care certificate.

Staff on the respiratory ward told us they were given specialist respiratory training by the research nurses and the consultant respiratory nurse.

Staff were encouraged to attended training opportunities and courses internally and externally and study leave was given. However staffing shortages meant that often study leave was cancelled or courses had to be attended in their own time.

The endoscopy department had developed an in-house training competency programme which met the specialist needs of the role. The training programme involved a structured process of practice, observations and assessment. These were undertaken by the team leader or matron. We reviewed four staff records and saw completed assessments.

**Appraisal rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From April 2017 to October 2017, 36.5% of staff within medical care at Arrowe Park Hospital had received an appraisal, compared to the trust’s target of 88%.

A split by staff group can be seen in the graph below:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals completed</th>
<th>Eligible staff</th>
<th>Appraisal rate</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health &amp; Community Health Services</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>8</td>
<td>17</td>
<td>47.1%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>207</td>
<td>532</td>
<td>38.9%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>197</td>
<td>546</td>
<td>36.1%</td>
<td>No</td>
</tr>
<tr>
<td>Medical and dental staff - Hospital</td>
<td>34</td>
<td>132</td>
<td>25.8%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>1</td>
<td>10</td>
<td>10.0%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>0</td>
<td>13</td>
<td>0.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>0</td>
<td>3</td>
<td>0.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff appraisal rates were low and did not meet the trust target. We were given the updated appraisal rates for February 2018 which covered ward 22, 21, 23, 27 and 32. The average appraisal rate across these wards was 67% with the lowest rate being 48% on ward 32. We were told appraisals had not been kept up to date due to staff shortages and pressures over the winter period.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. We observed a multidisciplinary team approach to patient care across the service and staff told us they were proud of their multidisciplinary approach.

Staff told us that daily multidisciplinary ward rounds were undertaken. We saw multidisciplinary team discharge huddles which included the integrated discharge team, consultants, physiotherapists, occupational therapy and dieticians. These took place twice a day on ward 22. Staff told us this had resulted in a positive and proactive approach.

Ward 23 which was a specialist stroke ward had a multidisciplinary team which supported patients through their recovery. We saw dedicated stroke co-ordinators who supported patients from admission. There was input from neurology physiotherapists, occupational therapists, speech and language therapists, specialist nurses and consultants. Patients were given the same multidisciplinary care into rehabilitation. Staff told us they felt well supported by the multidisciplinary team and had good links with community care teams.

We saw a pharmacy presence across all of the wards which we visited. Staff reported improvements in medicine management processes since the introduction of pharmacy in the teams. In the discharge hospitality centre, we saw a dedicated pharmacy technician who co-ordinated the processing of discharge prescriptions at ward level.
Staff on escalation wards reported that they did not have dedicated multidisciplinary input such as physiotherapists and occupational therapists. We were told they had access to services via a bleep system, this resulted in delayed reviews. This had been escalated and was being reviewed at matron level.

Seven-day services

Consultant cover was available seven days a week. Monday to Friday daily ward rounds took place on all wards. During the weekend there were two ward rounds which were undertaken to review patients who had been admitted overnight. There were two consultants on call at night. One provided cover for patients under 75 years and the other providing cover for patients over 75 years old. There was also specialist on call cover. On call was provided for renal, gastroenterology and cardiology specialties too. On weekends there were two post take ward rounds undertaken for firstly, frail elderly medicine and secondly, general medicine. There was also specific consultant cover provided on the medical short stay ward, gastroenterology, cardiology and renal wards. A discharge ward round was also undertaken on weekends to support patient flow. Medical cover was provided seven days per week and ward rounds were undertaken daily.

Physiotherapy and occupational therapy services were provided on the stroke ward over seven days.

The endoscopy department was open to outpatients six days per week Monday to Saturday. Staff told us there was a 24 hour on call service in place for patients requiring urgent endoscopy review. This was in-line with the trusts escalation policy for gastrointestinal bleeds and in line with national guidance from the national confidential enquiry into patient outcome and death.

There was a stroke co-ordinator available 24 hours a day. They co-ordinated the initiation of investigations and treatment for patients identified of having suspected transient ischemic attack and stroke.

The discharge hospitality centre was open seven days per week, however the dedicated pharmacy technician was not in place seven days. We were told the pharmacy department was staffed during the weekend and available to facilitate the provision of medicines to take home.

The trust had access to a chaplaincy service which provided 24 hour spiritual care if required.

Health promotion

We saw limited evidence of health promotion activities within the hospital and linking with the wider community.

We saw information leaflets for patients relating to various conditions on wards 37, 38, the discharge hospitality centre and in the information bank. The information was provided through the trust and external agencies. Examples of leaflets we saw were British lung foundation leaflets related to living with asthma, bronchiectasis and non-invasive ventilation.

The trust information leaflets provided patients with information such as preventing hospital blood clots, preventing pressure ulcers and wound care.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always understand their roles and responsibilities under the Mental Capacity Act 2005. There were delays in deprivation of liberty safeguards being applied for to ensure patients were not being deprived of their liberty unlawfully.

Mental Capacity Act and Deprivation of Liberty training completion

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust reported that their Protecting Vulnerable People (PVP) courses contain modules relating to the Mental Capacity Act (MCA), Deprivation of Liberty safeguards (DoLS) and Mental Health Act training. Data on the individual modules within these courses was not provided.

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

The breakdown of PVP training completion from April 2017 to October 2017 for nursing staff in medical care at Arrowe Park Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion %</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>276</td>
<td>344</td>
<td>80.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 3</td>
<td>116</td>
<td>203</td>
<td>57.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for PVP modules by nursing staff in medical care at Arrowe Park Hospital was 71.7%. Nursing staff did not meet the trust target for either PVP module.

The breakdown of PVP training completion from April 2017 to October 2017 for medical and dental staff in medical care at Arrowe Park Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Sum of Trained (YTD)</th>
<th>Sum of Eligible (YTD)</th>
<th>Sum of Completion rate YTD</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>36</td>
<td>93</td>
<td>38.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 3</td>
<td>14</td>
<td>39</td>
<td>35.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for the two PVP modules by medical staff in medical care at Arrowe Park Hospital was 37.9%. Medical staff did not meet the trust target for either module.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

As part of this inspection we looked at 14 patient records tracking patients with a learning disability, and best interest decision meetings on wards following deprivation of liberty safeguard applications.
The trust had a central safeguarding team who identified and coordinated the trust response to mental health capacity issues and deprivation of liberty safeguards. Staff informed us that they received support from the safeguarding team.

The service used a safeguarding pathway, patient’s capacity was accessed on admission and the trust computer system had a mandatory field for this assessment. When staff assessed the patient lacked capacity a formal capacity assessment was completed. If required a notification was put on the system to notify the safeguarding team that a deprivation of liberty safeguard application needed to be made to the local authority. The safeguarding team was not available seven days a week and worked Monday to Friday 9am to 5pm. This meant that if a safeguarding was raised at weekend it was only escalated to the local authority on the following Monday.

A deprivation of liberty means taking someone’s freedom away. A recent Supreme Court judgement decided that someone is deprived of their liberty if they are both 'under continuous supervision and control and not free to leave’. This may occur when a person who has been assessed not to have capacity to consent to their care and treatment, is cared for in such a way that restricts or impacts on their freedom.

We reviewed 14 records of patients who were on medical wards and had a deprivation of liberty safeguard in place and found there had been delays between the restriction being put in place and the application being made. Applications to the supervisory body should be made as soon as the restriction is put in place. We found 12 records showed there had been a delay in the application being made. The delays ranged from one day to 22 days. Six of these were over five days delay. This meant there was a risk that patients were potentially being deprived of their liberty unlawfully.

If staff had not submitted applications for deprivation of liberty safeguards to the local authority, following a capacity assessment and the patient was deemed to lack capacity, or the application had lapsed, the safeguarding team asked wards to conduct best interest decision meetings for care and treatment. There was also an online page to complete after such a meeting as part of the patient electronic records. We visited two wards with several patients whose deprivation of liberty safeguard application had lapsed and neither sister in charge of the ward recognised the form or could provide evidence of a best interest decision taking place.

While reviewing patient records on line and found patient records where staff had not completed the mandatory capacity assessment on admission. We spoke to the team responsible for the system and they were unaware that staff could bypass this mandatory field. This meant that the safeguarding team were unable to identify if there was a patient in the hospital who required a best interest decision or a deprivation of liberty safeguard. We brought this to the attention of the safeguarding team. We revisited these patients and one patient was identified as needing a deprivation of liberty safeguard application as result of this process during our visit.

Staff we spoke with on ward 36 told us they knew about and used deprivation of liberty safeguards appropriately. They worked with an independent mental capacity advocate for a patient who lacked capacity and had no family. Staff identified patients with deprivation of liberty safeguards in place by an umbrella flag on electronic records.

We saw evidence of consent obtained in the endoscopy department for patients undergoing endoscopic procedures. We reviewed four patient records and saw consent had been completed on all occasions. Staff told us that they recognised patients with additional needs and had a
separate area and process for obtaining consent for procedures, patients carers or family were included in the process.
**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. However, the response rates to formal patient surveys were low and patients’ dignity and privacy was not always maintained.

We carried out observations on wards 22, 23, acute medical unit and ambulatory care unit.

Patients and their relatives reported that staff demonstrated a caring approach. Comments such as staff are ‘so good if you paid them double it would not be too much’, ‘the nurse who sat with her was absolutely brilliant’ and ‘every time I come in the staff have been great you just can’t fault them’ were received from patients and relatives we spoke with.

We observed thank you cards on wards from patients and relatives which expressed gratitude for care, kindness, compassion and a professional approach. Information boards on wards displayed positive friends and family test results and included quotes such as ‘superb care received’.

Patients commented positively about the leadership on ward 19 and 36 and within acute medical unit describing staff as ‘outstanding’.

We observed that staff interacted with patients in a respectful and considerate way. On ward 23 we saw staff interacting with patients in a positive and cheerful manner. We observed a healthcare assistant on ward 12 demonstrating an understanding of the needs of a patient with a hearing impairment and adapting their communication style appropriately.

We observed that the service respected patients’ privacy and dignity needs. We observed staff closing curtains when assisting patient to get in and out of bed and to get dressed.

However, we also observed staff on the acute medical unit assisting a patient to dress in a bay without a curtain drawn round the bed. On ward 21 we observed patients who required assistance to eat were not offered support. During the evening meal we observed a patient struggling to eat his meal and though staff were present no assistance was offered and his food was taken away uneaten.

We observed male and female patients in the discharge hospitality centre dressed in nightwear. The service had identified this issue due to a complaint from a relative and had taken action to share learning from the complaint. Staff told us that patients were encouraged to dress before coming to the discharge hospitality centre and if they were in pyjamas they would be given a blanket to maintain privacy and dignity. However, on three separate occasions during our inspection, we observed male and female patients in nightwear with no blankets. The toilet in the area was mixed gender and was also used by physiotherapy patients.

The toilet in the surgical day case unit was designated for single sex use and the unit accommodated mixed gender patients in two separate bays. This meant that male patients had to use a commode. The shower was out of use so patients’ dignity was not preserved as they could not use the shower to wash and had to use a bowl by their bedside.
Though patients told us staff were kind and caring they also commented that staff were very busy. On the acute medical unit we received comments such as ‘all the staff are really good but just far too busy’ and ‘they are just too busy’. We also received comments on the ambulatory care unit and ward 23 that the staff appeared busy and ‘overworked’.

The site scored lower than the national average for other acute trusts in the privacy, wellbeing and dignity domain of the Patient Led Assessment (PLACE) in 2017 and also in the food domain. The site scored 79.61% in privacy, dignity and wellbeing compared to an average for acute hospitals of 82.4%. In the food domain the site scored 79.69% compared to a national average of 89.5% for acute hospitals.


**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the Arrowe Park Hospital was 17% between December 2016 and November 2017, compared with 25% nationally.

The top scoring wards at Arrowe Park Hospital in terms of recommendation rates were wards 22, 23 and 26 with 100% recommend rates for 10 months out of 11. Ward 36 scored 100% for nine months out of 11.

* Data only includes Wards with total responses above 100; Top 12 wards shown per site

(Source: NHS England Friends and Family Test)
Emotional support

The service had systems and facilities in place to provide emotional support to patients and relatives. Staff generally provided emotional support to patients to minimise their distress.

Staff demonstrated a sensitive and supportive attitude towards patients and relatives. The acute medical unit had won an award from the trust after providing end of life care for a husband and wife who had a young family; they arranged side by side beds in a relative's room for both patients.

The endoscopy department used a larger, quiet room for assessment and consent of patients who had additional learning needs or dementia where they could be accompanied by their carer.

The service liaised with the bereavement team to give relatives of patients who had died in hospital a 'tie for treasure' bag. This was a small handmade bag which contained personal items such as the patient’s ring which was then given to relatives. Staff reported they had received positive feedback from relatives about the comfort and emotional support this offered.

Staff offered appropriate support to patients with dementia to help them cope with their treatment. Patients were given ‘twiddle muffs’, cuffs made of wool or felt with items attached such as buttons. Patients were given these to reduce agitation and to fit around cannulas to prevent confused patients from pulling their cannula out. The cuffs were single use and could be taken home by the patient.

The service had volunteers who visited wards twice weekly to talk to patients and their relatives. Volunteers had a nominated point of contact in the patient relations team to feedback any issues or themes.

However, patients also reported that staff did not always show empathy and understanding. We received comments stating staff were ‘nearly always caring and compassionate…a bit low on empathy’.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

The service had pledged to follow ‘Johns Campaign’ for patients with dementia. Johns Campaign states that in hospitals carers of dementia patients should not just be allowed but should be welcomed, and that collaboration between patients and all connected with them is crucial to their health and their well-being. The service provided fold up beds for carers to stay with patients and ward 27 had identified and obtained funding to turn a large unused room into a relative’s room. The dementia wards had open visiting hours for relatives and carers.

Ward 30 (haematology) worked with the Candice Colley Foundation which aims to help patients with leukaemia and other blood cancers and their families. The foundation funded a relative’s room for families to stay overnight on the ward.
The service provided a ‘Sister’s Surgery’ on ward 27. We saw posters displaying the days and times when relatives could attend a drop in and discuss their relative’s care and treatment. The poster also provided a phone number and email for relatives who could not attend at those times.

On the ambulatory care unit we observed a trainee practitioner responding clearly and politely to a patient’s query about their treatment. The patient was concerned that they needed to eat but could not whilst undergoing treatment. The member of staff sought advice and brought the patient something to eat.

However, patients also told us that they did not feel that all staff communicated with them and their relatives in a timely manner. One relative reported that staff had given their relative a drink which was not suitable as the patient had difficulty swallowing and that the patient had been prescribed medication that they felt he did not need. They were able to discuss this with the doctor later and come to agreement with the staff and doctor. Another relative told us they felt ‘communication had not been good enough’ and they had not been involved in or received feedback from a multi-disciplinary team meeting.

Is the service responsive?

Service delivery to meet the needs of local people

The service provided services in a way that met the needs of the local population and worked with public health organisations to help maintain up to date knowledge of needs.

On the wards we visited we saw dementia champions working (champions are someone with extra knowledge and skills in this area). Staff used forget me not symbols on electronic patient records to help identify patients with these needs.

The service had access to a learning disabilities nurse who was available Monday to Friday 9.00am-5.00pm. Nurses told us the learning disabilities nurse was very supportive. Patients identified as having learning difficulties triggered the use of a reasonable adjustments care plan. The care plan helped staff to assess needs and determine the level of support required.

The trust was working as part of Healthy Wirral to improve access to services and meet the needs of the community. This was midway through a five year process incorporating actions such as introducing discharges to intermediate care beds.

Average length of stay

Trust Level

From October 2016 to September 2017 the average length of stay for medical elective patients at the trust was 23.2 days, which was higher than the England average of 4.2 days.

The average length of stay for elective patients in Nephrology (40.4 days) was much higher than the England average of 8.5 days.
Elective Average Length of Stay – Trust Level

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

For medical non-elective patients, the average length of stay was 6.6 days, which was the same as the England average.

The trust had lower lengths of stay in General and Respiratory Medicine when compared to the national averages.

Non-Elective Average Length of Stay – Trust Level

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

Arrowe Park Hospital

From October 2016 to September 2017 the average length of stay for medical elective patients at Arrowe Park Hospital was 20.8 days, which was longer than England average of 4.2 days.

The average length of stay for elective patients in Nephrology (34.6 days) was much higher than the England average of 8.5 days.

Elective Average Length of Stay - Arrowe Park Hospital

Note: Top three specialties for specific trust based on count of activity.
For medical non-elective patients, the average length of stay was 6.5 days, which was similar to the England average of 6.6 days.

The trust had lower lengths of stay in General and Respiratory Medicine when compared to the national averages

**Non-Elective Average Length of Stay - Arrowe Park Hospital**

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

(Source: Hospital Episode Statistics)

Above average length of stays were attributed primarily to delayed transfers of care to community services. The service identified this was a concern and were working with their local commissioner to address this, with initiatives such as a discharge team to help bridge gaps between hospital and intermediate care.

**Meeting people’s individual needs**

The service took account of patient’s individual needs.

The service holistically assessed patient’s needs. We observed staff using the electronic nursing assessment which was completed on admission, we reviewed 22 records across four wards and these were consistently completed. The checklist reviewed the patients physical, mental health, social, religious and nutritional needs and triggered the appropriate referrals to meet patient’s individual needs. It also triggered the need for additional input from the multidisciplinary team such as physiotherapists, dieticians and social referrals.

A dementia matron managed initiatives to improve care for dementia patients. The matron explained a process whereby hospital ward staff and care home staff in the community could access dementia training. We were told the courses were half a day sessions, delivered by the matron every eight weeks. The training was mandatory for ward based staff and was included in the protecting vulnerable people training.

The service focused on ensuring the environment met the needs of patients living with dementia and provided dementia friendly facilities on wards 21, 22 and 27. The elderly medicine wards and the discharge hospitality centre had memory areas which contained items from the past and a more comfortable area for patients to spend time.
We saw that ward 21 had a dedicated bay for dementia patients or those with delirium which contained specially adapted equipment such as a dementia friendly clock, large calendar, a radio and games. Female patients on ward 27 used a room to have hair and beauty treatments which was decorated as a 1950’s hair dressing salon. On ward 21 male dementia patients could access a day room which was equipped as a pub and had a fridge containing soft drinks for patients. There was also a bus stop in the centre of the ward and staff reported that patients enjoyed sitting there whilst walking along the ward corridor and that it prevented patients from becoming distressed when confused or wandering.

Staff used a pathway to help care for patients with learning difficulties which included the use of reasonable adjustment care plans and ‘my healthcare passports’ which outlined patients needs and communication preferences. On ward 36 we observed reasonable adjustments made to take account of the needs of a patient with a learning disability. Staff cared for the patient in a side room in line with her preferences. We reviewed the patient notes and saw that a comprehensive ‘My Health Passport’ was completed as well as a reasonable adjustment care plan and risk assessment. The patient had a percutaneous endoscopic gastrostomy tube and staff reported that they had worked with the independent mental capacity advocate and the patient to ensure they acted in the patient’s best interests and with appropriate consent.

Wards used a picture book called ‘Communication with Pictures’ for patients with learning or communication difficulties or who did not speak English. The picture book was used to help patients communicate their basic needs. It contained sections on allergies, feelings, food and drink, actions, personal items and people. Some sections such as allergies were translated into additional languages such as Polish, Punjabi, Urdu and Russian.

Staff had access to an interpreting and translation service ‘the one stop shop’ which provided interpreters for different languages and communication styles such as sign language. The service was provided face to face or over the phone. Staff knew how to access the service via the trust intranet page.

**Access and flow**

People could not always access the services when they needed it.

The trust was struggling to cope with the number of patients requiring care. This meant that the hospital was often operating at full capacity. Additionally patients were not always discharged as quickly as they should be.

The service provided data for September 2017 to February 2018 that demonstrated that average bed occupancy rates were 92.6%, rising from 86.6% in September 2017 to 95.2% in January 2018. Ward 36 had bed occupancy above 100% for the whole period, an average of 102%. Ward 37 had a bed occupancy rate in February 2018 of 111.2%. Bed occupancy rates above 85% can compromise patient safety and can increase the risk of infection. High rates also mean the service has less capacity to respond to unexpected demands.

Meetings were held to monitor the access to beds through the hospital. These were held three times per day at 8.45am, 12.00pm and 4.00pm. We observed a bed meeting which was attended by service leads and the integrated discharge team. The meeting addressed expected admissions and identified numbers of patients to be discharged, against the number of available beds in the
hospital. The meeting addressed where patients required beds and identified patients who could be moved to escalation areas. We did not see evidence that the acuity of patients was considered in this process. We also observed that there was no discussion around involvement of other providers such as social services or primary care.

Issues with patient flow resulted in escalation beds being opened in areas which were not routinely used for medical patients. Information provided by the service showed that there was a shortage of medical beds and a number of patients placed on wards that were not best suited to meet their needs (also known as outliers). We saw evidence of this in five areas. At the time of the inspection on one day there were 50 medical outliers. We were told that there was a consultant rota to ensure patients received a senior review.

We saw that the service accommodated medical outliers on the surgical day case unit, ward 12 and ward 14. We reviewed incident reports for these areas and saw that on ward 14 staff had raised concerns on three occasions about the acuity of patients assessed as suitable to be medical outliers and also lack of a doctor’s review.

During our inspection ward 19 had nursing ratios of 1:13 at night. Staff told us that escalation areas operated outside of their standard operating procedure. They informed us that the ward received patients who were living with dementia or who were on end of life pathways, mainly in evening and weekends. They also told us that the ward had received patients who had not been medically optimised prior to transfer to the ward. The standard operating procedures for ward 19 stated the ward must adhere to moving patients before 5pm however, the trust reported bed moves on this ward at night as 61 in October 2017 and 47 in November 2017. Staff on this ward told us that they felt pressured to accept and move patients.

We saw that beds were opened overnight in the ambulatory care unit on two occasions in July 2017 with no registered nurse staff allocated after 2am. Staff reported that registered nurse cover was provided from the acute medical unit which impacted on patient care within the acute medical unit.

The surgical day case unit was used as an escalation area for medical inpatients. We saw and staff reported that the area did not have appropriate facilities and equipment for medical outliers. We reviewed 17 incident records for the unit for December 2017 to March 2018. Staff had reported concerns such as not enough call bells available for all inpatients, lack of medicine stock, insufficient toilets, lack of shower facilities, inability to isolate patients displaying symptoms of infection, lack of manual handling equipment and lack of medical cover.

We observed that the ambulatory care unit trolley area was used as an inpatient bed area and management confirmed this was used for patients as an escalation area. Staff told us that the bay accommodated ill and frail patients for more than 16 hours and did not have established staffing after 11pm. The acute medical unit provided staff for this area after 11pm impacting on their staffing levels.

Staff informed us that on one day in March 2018 the ambulatory care unit accommodated 12 patients overnight, seven in chairs, and one registered nurse staffed the area. They told us that they accessed the on call junior doctor or consultant to escalate patients with deteriorating health. Staff informed us that patients waited on trolleys in the unit and corridor waiting times were not
monitored. On reviewing the bed bureau incidents between January 2017 and December 2017, we found that there were a significant number of occasions when the unit had been used overnight and patients cared for on trolleys rather than beds. Also there were incidents reported when patients had been accommodated overnight in the clinic rooms. Data provided by the service showed that between March 2017 and February 2018 the average waiting time for patients in the trolley area of the ambulatory care unit before being transferred to a ward was 6.25 hours. However, five patients had waited over 12 hours in the same period and 26 patients had waited over eight hours.

The bed management team used the electronic patient record system to monitor patients in outlier wards and ensure senior review. We saw this was happening in most of the areas, however this was highlighted as an issue on ward 25 which was the outlier ward for infection prevention and control. We reviewed eight patient notes on this ward and identified four patients who had not had a consultant review for two days or more and two patients who had not had a consultant review since admission.

Delayed discharges occur when patients are being discharge home or to supported care facilities. They can affect waiting times for care as delayed transfers of care reduce the number of beds available for other patients. Information provided by the trust showed between December 2016 and November 2017 there were 1655 delayed discharged from medical wards.

The service had identified patients transferred between wards at night as an issue. Patient transfers from assessment areas and late discharges were identified as a cause. We reviewed the Integrated Quality Governance Report for March 2018 which stated that in January 2018 across the trust 33 patients with dementia moved wards between 9pm and 7am. The data provided by the trust showed an upward trend in the number of transfers at night for ward 23 from July 2017 when there were 15 to February 2018 where there were 40. The senior leadership team identified that this was an area of concern and that work was being undertaken with the dementia matron to create a ‘who can be moved list’.

The service used the SAFER patient flow bundle to assist patient flow. Data provided by the trust showed that across all medical wards at the hospital the number of bed moves at night between 1 December 2016 and 30 November 2017 was 7,753. Moves at night occur between the hours of 10pm and 8am. This excludes transfers from the accident and emergency unit. Data also showed that in February 2018 183 patients had been discharged from the medicine service after 10pm at night. We were told discharges were undertaken later in the day due to delays in setting up packages of care. Staff did not identify discharges after 10pm as an area of concern despite the data.

The trust did not provide the number of patient moves per admission for each ward, therefore we were unable to compare this with what we found at the last inspection.
Patient moves per admission

Ward 32:

The trust reported that from December 2016 to November 2017 99% of patients had appropriate ward stays on ward 32 and the remaining 1% were outlier ward stays. The previous year’s performance was the same.

Ward 36:

The trust reported that from December 2016 to November 2017 99% of patients had appropriate ward stays on ward 36 and the remaining 1% were outlier ward stays. The previous year’s performance showed 97% of patients had appropriate wards stays and 3% were outlier ward stays.

Ward 38:

The trust reported that from December 2016 to November 2017 98% of patients had appropriate ward stays on Ward 38 and the remaining 2% were outlier ward stays. The previous year’s performance was the same.

(Source: Trust Routine Provider Information Request (RPIR) P53 – Ward Moves)

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

From December 2016 to November 2017 the trusts referral to treatment time was consistently worse than the England average. In the latest month November 2017, the trust’s performance showed 75% of patients were treated within 18 weeks compared to the England average of 88%.

The trend over time remained consistent.

(Source: NHS England)
The service had introduced a practice of ‘boarding patients’. This meant that patients who had been identified as fit for discharge were moved to seated areas on other wards to free up a bed for patients awaiting admission. At the time of our inspection the service was developing a standard operating procedure and risk assessment for this. There had been incidents raised regarding inappropriate boarded patients on wards who did not have sufficient staffing numbers to provide care. The service was investigating an incident at the time of our inspection.

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

Three specialties were above the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>95.4%</td>
<td>94.0%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>100%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>98.2%</td>
<td>97.9%</td>
</tr>
</tbody>
</table>

Four specialties were below the England average:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>64.7%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>91.5%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>80.5%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>65.9%</td>
<td>84.2%</td>
</tr>
</tbody>
</table>

We requested further information from the trust on initiatives they had in place to improve referral to treatment times. However, the trust did not provide any feedback or information relating to this.

**Learning from complaints and concerns**

**Summary of complaints**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From November 2016 to November 2017 there were 80 complaints about medical care at Arrowe Park Hospital. The trust took an average of 68.6 days to investigate and close complaints.

The trust had not provided details of the level of the complaints. Their complaints policy states that level 2 complaints should be closed within 25 days; level 3 complaints within 45 days; and complex level 4 complaints in 60 days.

The main themes from the 80 complaints were:

- Patient care - 32 complaints.
- Communications – 18 complaints
- Admissions and discharges (excluding delayed discharge due to absence of care package) – 14 complaints

(Source: Routine Provider Information Request (RPIR) P61 Complaints)
The service treated concerns and complaints seriously and investigated them. However, this was not always in a timely manner. Lessons learnt from the results of investigations were shared with all staff.

We did not see information displayed for patients and relatives on how to raise concerns, complaints or give feedback. Staff told us that if individuals raised a concern or complaint they would make them aware of the trust's patient liaison service. They would also refer the individual to senior nurse in charge.

The service did not always investigate complaints in a timely manner as outlined in the trust policy. The patient experience department has appointed an interim complaints manager who was undertaking an improvement plan. The main objectives for the improvement plan were to improve the quality of responses, the response timeframes in line with policy and the promotion of the service.

The service provided a ‘matron hotline’ which was a telephone number for relatives or patients to call and directly raise any concerns with a manager. Ward staff told us that they had seen a reduction in the number of complaints since introducing the service. However, we did not see evidence of this widely advertised around the hospital. The patient experience team told us that there was no data available on the impact of this initiative.

Lessons learnt from complaints were shared in safety huddles and ward team meetings.

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Is the service well-led?

**Leadership**

The service did not have sufficient managers at all levels to run a service providing high-quality sustainable care. The service had gaps in leadership posts especially at senior nurse and clinical lead level.

The service had reviewed and restructured medical and nursing leadership in November 2017 and produced a new divisional structure for medical and nursing leadership. However, we did not find evidence that leadership development plans had been put in place to mitigate the impact of the restructure or succession plan for future leadership within medical services.

Managers acknowledged that the restructure had led to disengagement from medical staff. Medical staff told us that four consultants had left and they had escalated concerns to board level. The service reported their intention to advertise for a clinical service director.

At the time of our inspection the service had gaps in nursing leadership at matron level, with only two matrons and one interim matron employed. Staff told us that when a matron had left the previous year the workload had been shared between existing matrons and there had been no recruitment. The service had identified the gaps in nursing leadership and had proposed a new structure which included four additional matron posts. The service had started recruitment of
matrons and substantive staff for ward 19. However, the new structure had not been ratified by the executive team or board at the time of our inspection.

The operational lead for medicine was new in post at the time of our inspection and there were plans to change the structure at triumvirate level. Staff reported that they found the Director of Nursing and Deputy Director of Nursing supportive though this support had only improved recently.

Staff reported that leaders at executive team and board level were not visible to staff at ward level. We reviewed the schedule for the trust board partner visit for 2017. This demonstrated that some areas had visits cancelled such as ward 30 and others such as the discharge hospitality centre had not had a visit scheduled since 2016. Each ward had an executive team member allocated to them but staff told us they had not met them and they had not visited their ward. One member of staff described how they had asked to see a board member but had been told there was no one she could speak to. Staff on the acute medical unit told us that that since a change in the executive team two years previously there had been little engagement with staff at ward level.

Leaders demonstrated an understanding of the challenges the medical division faced and could identify actions to address them. However, they struggled to implement change due to the lack of devolved governance structures to divisional level and financial pressures. They also said some of this was due to ‘the amount of bureaucracy in the trust’.

However, staff we spoke with were positive about their immediate managers and told us they were visible and supportive as they could be given the low numbers of matrons. Though staff told us they felt they were not supported from a more senior level to deliver safe care and treatment to patients. Staff told us the Deputy Director of Nursing conducted a fortnightly walk about around the wards.

Leaders had provided strong, compassionate and proactive support to staff on the cardiology ward during a recent bereavement. The medical director and chief executive had visited the ward and spoken to staff following the unexpected death of a nursing colleague.

**Vision and strategy**

The trust had a vision for what it wanted to achieve but did not have workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Staff were not able to describe the vision and strategy of the organisation to us and were not aware of their role in achieving the strategy. They told us that they did not feel that the service had plans to deal with low staffing levels and they were not aware of any recruitment or retention strategy.

We saw that the service had developed a ‘plan on a page’ which outlined six key priorities for 2017 to 2019. However, the plan did not include any workload, income or expenditure details. It was unclear how the priorities were going to be met and within what timeframes as no actions or milestones had been identified. There was no evidence that the plan had been developed collaboratively with staff and people who used services. Some staff we spoke with said they had
not been consulted about the new divisional workforce structure, though senior nursing staff were aware of it.

However, staff were able to explain and relate to the trust ‘PROUD’ values. They knew that this stood for patient, respect, ownership, unity and dedication and display boards in ward areas aligned outcomes and feedback to the PROUD values.

Culture

Managers across the service did not always promote a positive culture that supported and valued staff, there was not a sense of common purpose based on shared values.

Staff told us that morale was low across the service. They told us that concerns about safe staffing levels left them feeling demoralised and upset and we were told that staff were often in tears and experiencing high levels of stress. Staff felt that concerns raised about safe staffing were not listened to by senior managers and they did not get feedback when reporting concerns. Staff told us that they had submitted proposals for a staffing protocol for acute medical unit on three occasions and had not received feedback on these proposals. We reviewed incident reports detailing lack of sufficient and appropriate staff and saw that on three occasions staff had been referred to occupational health support due to stress levels after they had raised such concerns. Sickness rates were above trust targets and 25% of sickness reported in January 2018 was due to stress, anxiety or depression.

Nursing morale was low due to the high number of times nurses were moved to cover other wards. Staff told us 21 nurses had left the organisation in the last 12 months and that nursing staff were leaving the trust due to low morale caused by being moved around different areas to provide cover.

Staff told us they were fearful of talking to the Commission and expressing concerns. They told us they had little faith in the trust to address concerns. One area had 21 incidents forms completed over one weekend, they reported that they had not received support from senior management at this time.

Not all staff we spoke to were aware of the freedom to speak up guardian. Freedom to speak up guardians are there to encourage and enable staff to speak up safely about concerns within their own workplace.

The number of staff who would recommend the trust as a place to work measured through the staff Friends and Family Test (FFT) had decreased since 2016 and was less than the national average of 63%.

<table>
<thead>
<tr>
<th>Staff Friends and Family Test Questions</th>
<th>Q1 2016/17 Staff FFT</th>
<th>Q2 2016/17 Staff FFT</th>
<th>Q3 2016/17 Staff Survey</th>
<th>Q4 2016/17 Staff FFT</th>
<th>Q1 2017/18 Staff FFT</th>
<th>Q2 2017/18 Staff FFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1 Recommend Trust for Care</td>
<td>79%</td>
<td>86%</td>
<td>69%</td>
<td>78%</td>
<td>79%</td>
<td>79%</td>
</tr>
<tr>
<td>Question 2 Recommend Trust to work</td>
<td>58%</td>
<td>64%</td>
<td>62%</td>
<td>58%</td>
<td>57%</td>
<td>52%</td>
</tr>
<tr>
<td>Staff Engagement Score</td>
<td>3.82</td>
<td>3.97</td>
<td>3.78</td>
<td>3.78</td>
<td>3.76</td>
<td>3.70</td>
</tr>
</tbody>
</table>
There were mechanisms to provide staff with the development they needed, however they were not always implemented. For example from April 2017 to October 2017, only 36.5% of staff within medical care at Arrowe Park Hospital had received an appraisal, compared to the trust’s target of 88%. In February 2018 only 48% of staff on cardiology had received an appraisal, staff told us the low incident of appraisal was due to staffing pressures. Appraisals are important as they provide the opportunity to acknowledge the work that staff have done and offer encouragement for them to strive to high levels of achievement as well as managing their performance.

Medical staff told us that they had concerns regarding medical staffing levels and had escalated concerns. They felt previous reviews had not led to positive change and told us they had requested a review by the Royal College of Physicians as they had lost trust in the organisation.

Senior nursing staff felt they provided a leadership role for nursing and support staff and that staff were empowered to speak to them. They described a culture that held professional boundaries in place and where leaders held staff to account. Staff told us that they felt supported by ward sisters and they were able to raise issues with them. However, some staff told us that the matrons did not have the time and capacity to provide sufficient support to wards.

However, staff at all levels also told us they felt proud of their own teams and how they had managed recent media attention and staffing pressures. Staff on cardiology reported feeling valued by the response of senior leaders to the sudden death of their colleague.

**Governance**

The trust did not consistently use a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The service had a clear governance structure and defined lines of accountability from ward to board; however these did not always support the delivery of good quality and sustainable services. All levels of governance and management did not interact with other effectively.

There were inaccuracies in the data and assurance provided to the audit committee regarding nurse staffing levels reports which were being addressed through the NHS Professionals interface project. We reviewed an audit committee paper which stated that nurse staffing issues were not wide spread or consistent across the organisation and a report would be produced for the board in relation to care hours. During our inspection we found that staff at all levels and across the service raised concerns regarding nurse staffing levels and there were a number of areas that did not have sufficient and appropriate nursing staff to provide safe care and treatment to patients.

We saw that where task and finish groups had taken place to address performance or risk issues these groups were not formal and minutes were not always available. For example, a task and finish group had been configured to improve the environment in the discharge hospitality centre but no formal minutes were available.
The divisional management team held monthly clinical governance and quality improvement meetings which were attended by senior staff. We reviewed agendas and minutes of this meeting for September 2017 to January 2018 and saw they included a comprehensive overview of clinical governance and quality improvement issues discussed against the five key areas of safe, effective, caring, responsive and well led. We saw that the agenda included performance measures, clinical incidents and serious incident reviews, medicines management and governance and risk assessments. There was evidence that information was shared with other committees and groups to share learning.

However, not all speciality reports, risks and areas of performance were discussed at every meeting. Actions were not clearly defined and identified within the minutes. This meant that there is a risk that actions would not be completed in a timely manner. The meeting was limited in November 2017 as it was not quorate and we saw that trust wide health record audits had only been discussed for quarter one, therefore the divisional management team did not have up to date assurance on these.

**Management of risk, issues and performance**

The service did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service had an escalation policy to manage the pressures created by an increase in the number of medical admissions. Leadership told us that opening of escalation areas followed the standard operating policy and was recorded on the trust risk register. The trust had a safety checklist for opening an escalation area, kept in the bed management office and used every time an area opened. However, we saw that escalation areas did not fully comply with this policy and we did not see evidence that safety checklists and risk assessments were always completed prior to opening an area.

Management acknowledged concerns about overcrowding on the ambulatory care unit and that it was staffed to the detriment of the acute medical unit staffing levels. Staff told us they had escalated these concerns and we saw that lack of full establishment of staff on the acute medical unit had been placed on the risk register in October 2017. We reviewed the service risk register and saw that inability to recruit registered nurses had been on the risk register for over 24 months. However, we did not see evidence of a robust service recruitment and retention strategy to address these issues, though managers told us they have put forward a plan to the trust board for approval to fully staff the acute medical unit and ward 19.

The service had developed a workforce plan in December 2017 for 2018 to 2019 and for 2019 to 2022. We reviewed this plan and saw that actions had been identified to review rosters and establishment and to address pressure on staffing levels through recruitment of clinical support workers. The service had also identified training numbers for 2018 including six nurse apprenticeships, one clinical support worker apprenticeship per ward and 12 nursing associates in two cohorts.

Staff told us that there was a misalignment between the level of responsibility taken at senior level and ward level for risks to patient safety.
The service operated a medical manager of the day system to manage risk, issues and performance and matrons led the system for assuring safe staffing levels on a daily basis.

On reviewing the medical risk register we found that at the end of March 2018, 27 risks had reduced in score since it was last reviewed, seven had increased and 47 had remained the same. However, not all risks were reviewed at the same time. Forty eight risks on the register were less than one year old but there were 24 which had been on the risk register for over two years. For example, there was a risk that was placed on the risk register in January 2013 around the lack of an electronic system in endoscopy. Actions had been put in place but it was unclear if all these actions had been completed.

There was a further risk that had been added to the risk register in March 2014 around the risk of non compliance with national guidance in the assessment and management of head injuries. There were actions identified with a due date of September 2014, however, these actions had been continually extended and had still not all been completed. Therefore, we were not assured that all risks were being managed in a timely way.

We reviewed the agenda and minutes for the divisional management team clinical governance meeting. We saw that risks were identified and reviewed and the performance dashboard was reviewed.

Matrons carried out monthly audits to monitor compliance and performance against a number of areas including medicines safety, falls, pressure ulcers, incident investigations and infection control measures. Performance was rated red, amber or green and shared electronically with the wards.

We saw that the overall performance dashboard was discussed at the divisional management team clinical governance group in March 2018. We reviewed the divisional performance dashboard for December 2017 and saw that although performance had improved since November 2017 for some indictors a number of indictors had not been rated. We reviewed the action log for the patient flow improvement group leads for 2017 to 2018 and saw that actions had been identified with clear responsibilities and time scales.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The service collected and monitored performance information through monthly dashboards and this information was shared with the wards through matrons. We saw that information from the performance dashboard was displayed at ward level. Matrons monitored and reported performance measures to each ward and conducted monthly audits of performance measures in their areas. All managers we spoke with were aware of areas to improve their wards performance.

Staff had access to the information they needed to undertake their roles effectively. Policies and procedures were available and accessible via the trusts intranet facility. Important information such as safety alerts and key messages was shared in daily ward ‘huddles’ to help keep staff up to date and aware of issues.
The service had robust policies and procedures to ensure the integrity and confidentiality of data and information systems, including policies on information security, information disclosure, data quality and an information asset policy. We reviewed these policies and saw that they were in line with relevant data security standards and took account of national legislation such as the Data Protection Act 1998 and Freedom of Information Act 2000. Staff received mandatory training in data security. However, training compliance rates were low. Data provided by the trust showed that between April and October 2017 only 6.8% of medical and nursing staff had completed mandatory data security training and information governance training compliance was not included on the divisional performance dashboard for December 2017.

Not all staff had access to patients’ records and diagnostic tests. Staff we spoke to stated that not all bank and agency staff had access to or could use the electronic records system. Some staff told us that they had not yet received training in the system. Historical patient records were still paper based and not connected to the electronic record. This meant that wards were using a dual system of electronic and paper based patients’ records and staff had to look in different places for information.

Engagement

The service did not always engage well with patients, staff and the public to plan and manage appropriate services. However, they did work in partnership with other trusts to improve services.

Response rate to the national staff survey in 2017 was below the national average of 45% with only 31% of staff responding, a reduction from 46% in 2016. In the acute and medical division 65% of staff reported that they felt able to contribute towards improvements at work. Only 19% of staff in the division reported good communication between senior management and staff.

Staff told us that though they completed the annual staff survey they did not receive feedback and were not aware of action plans arising from it.

The service had a staff satisfaction and engagement plan which was discussed at the workforce and communications group. We reviewed minutes from this group and saw that the trust conducted an internal communications survey in October 2017. The survey highlighted that though 76% of staff had regular team meetings, the least effective areas of communication were between staff and divisional managers.

However, there were systems to support improvement and innovative work by staff including a staff recognition scheme called the ‘PROUD’ awards. The PROUD awards event took place in September 2017 and included awards for patient focus, quality improvement, research, safety and learner of the year. The awards celebrated individual success as well as team performance.

We spoke to the patient experience team and visited the information bank located in the main reception area. They told us that patients were able to raise concerns through talking to staff, attending the information bank, telephoning or emailing and calling the matron hotline. However they told us that a recent audit showed that the majority of wards did not display posters and leaflets about this.
We saw that the impact of the engagement initiatives such as the matron hotline was not measured or audited. Therefore, there was limited evidence of engagement with patients and the public.

The trust engaged with the public through its membership strategy. The trust distributed membership newsletters to invite people to have an input into the trust and services. However, during our inspection we did not find copies of this newsletter available on wards or patient areas.

The service collaborated with partner organisations effectively. An information bank for patients and visitors opened in January 2018 in partnership with Healthwatch Wirral. The information bank was staffed jointly by the trust and Healthwatch Wirral and had received an ‘Outstanding Nomination’ award from Healthwatch England. We reviewed Healthwatch Wirral reports regarding the dementia environment that showed that the service welcomed visits and feedback from Healthwatch.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong.

A weekly safety summit was chaired by the medical director. We observed the summit during our inspection and saw that it was attended by over 30 staff of different grades and disciplines including those from medical services. The summit presented a few recent incidents to identify areas common to practise across the trust and share immediate learning and actions. The staff member involved directly in the incident presented it to the safety summit. The trust shared information from the safety summit through the weekly ‘Safety Bytes’ electronic bulletin. We reviewed the bulletin following the summit and saw that it was reflective of the discussions and highlighted key learning points for staff.

The summit we observed demonstrated an approach to continuous improvement that did not blame staff but focussed on learning from incidents.

The service participated in some accreditation schemes but did not consistently participate in research and external reviews.

In the endoscopy department the joint advisory council on endoscopy accreditation was reviewed and renewed in January 2018.

Community geriatricians were working in partnership with local nursing homes, primary care and community services developing older people’s rapid assessment clinics to improve the pathways for older patients between services.

The service had a research and development manager and some staff had expressed an interest in being involved in research. However, we spoke to a member of staff involved in research who told us medical staff were not given protected time for research and they did not get support from the service for research.
Wirral University Teaching Hospital NHS Foundation Trust

Evidence appendix

Arrowe Park Hospital
Arrowe Park Road
Upton
Wirral
CH49 5PE

Tel: 0151 678 5111
www.wuth.nhs.uk

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.

Acute services

Surgery

Facts and data about this service

Arrowe Park Hospital provides a range of surgical services including general surgery, urology, ear, nose and throat, ophthalmology, orthopaedic trauma and elective surgical services in a mixture of longer stay and short-stay wards.

There is also a day surgery unit, a surgical assessment unit (SAU) a surgical elective admissions lounge (SEAL) and the Wirral Acute Femoral Fracture Unit (WAFFU).

The trust had 34,088 surgical admissions from October 2016 to September 2017. Emergency admissions accounted 9,872 (29%), 18,890 (55%) were day case, and the remaining 5,326 (16%) 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

Mandatory training completion rates

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

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for nursing/midwifery staff in surgery is shown below:

Arrowe Park Hospital:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Safety Level 2</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>CPR</td>
<td>123</td>
<td>296</td>
<td>41.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block B</td>
<td>106</td>
<td>297</td>
<td>35.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block A</td>
<td>58</td>
<td>297</td>
<td>19.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security 1</td>
<td>52</td>
<td>297</td>
<td>17.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management Level 2</td>
<td>3</td>
<td>37</td>
<td>8.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Please note that Block A contains Manual Handling, Health & Safety Level 1, Risk Management Level 1, Consent Awareness, End of Life Care and Moving & Handling modules. Block B contains Fire Safety, Infection Prevention & Control and Medicines Management modules.

The overall completion rate for mandatory training modules by nursing staff in surgery at Arrowe Park Hospital was 28.1%. Nursing staff met the trust target for one of the six mandatory training modules. However, for the remaining five courses, the completion rates were below 42%.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical and dental staff in surgery is shown below. All of the staff were based at Arrowe Park Hospital.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td>60</td>
<td>144</td>
<td>41.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block B</td>
<td>57</td>
<td>144</td>
<td>39.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block A</td>
<td>40</td>
<td>144</td>
<td>27.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security 1</td>
<td>16</td>
<td>144</td>
<td>11.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management Level 2</td>
<td>10</td>
<td>112</td>
<td>8.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Please note that Block A contains Manual Handling, Health & Safety Level 1, Risk Management Level 1, Consent Awareness, End of Life Care and Moving & Handling modules. Block B contains Fire Safety, Infection Prevention & Control and Medicines Management modules.

The overall completion rate for mandatory training modules by medical and dental staff in surgery at the trust was 27.5%. Medical staff did not meet the trust target for any of the five mandatory training modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Mandatory training was available via on-line courses as well as face to face and staff reported this was easy to access. Email reminders were sent to advise staff when they were required to complete a refresher course and attendance was monitored through monthly divisional compliance reports.

Sepsis 6 training was incorporated into resuscitation training (CPR).

Further information regarding mandatory training compliance was obtained at the time of our inspection. The mandatory training compliance report for February 2018 for the surgical division showed an overall compliance rate of 72%. Compliance per staff group was 71% for medical and dental staff of 73% for nursing and midwifery registered staff. This showed an improvement in compliance but was still below the trust target.

<table>
<thead>
<tr>
<th>Module</th>
<th># compliant</th>
<th>% Compliant</th>
<th># Non compliant</th>
<th>% Non compliant</th>
<th>Total Staff</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>1929</td>
<td>71%</td>
<td>805</td>
<td>29%</td>
<td>2734</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>6473</td>
<td>73%</td>
<td>2417</td>
<td>27%</td>
<td>8890</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>8402</td>
<td>72%</td>
<td>3222</td>
<td>28%</td>
<td>11624</td>
<td>No</td>
</tr>
</tbody>
</table>

Safeguarding

Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to and staff knew how to access them. Staff described how they obtained advice and support from the safeguarding team and could describe the process they would use to escalate a safeguarding concern.

Safeguarding training completion rates

The trust reported that their Protecting Vulnerable People (PVP) courses contain safeguarding adults and children modules. Data on the individual modules within these courses was not provided.

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

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for nursing/midwifery staff in surgery is shown below:
Arrowe Park Hospital:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>180</td>
<td>293</td>
<td>61.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 3</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 1</td>
<td>0</td>
<td>3</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for PVP courses by nursing staff in surgery at Arrowe Park Hospital was 60.6%. Nursing staff did not meet the trust target for any of the three PVP courses.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical and dental staff in surgery is shown below. All of the staff were based at Arrowe Park Hospital.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>62</td>
<td>143</td>
<td>43.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 1</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for PVP courses by medical and dental staff in surgery at the trust was 43.1%. Medical and dental staff did not meet the trust target for either of the two PVP courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Further information regarding mandatory training compliance was obtained at the time of our inspection. The mandatory training compliance report for February 2018 showed a compliance rate of 84% for the module Protecting Vulnerable People Level 2 in the surgical division.

Compliance rates for medical staff ranged from 64% in the special surgery directorate to 90% in the anaesthetics and theatre directorate.

Compliance rates for nursing and midwifery registered staff ranged from 75% in the general surgery directorate to 93% in the trauma and orthopaedic directorate.

This showed an improvement in compliance rates but was still below the trust target of 95%.

Cleanliness, infection control and hygiene

Most areas we visited were visibly clean however we observed inconsistent completion of cleaning checklists where they were present.

Adequate hand washing facilities were available and hand gel dispensers were positioned at multiple areas throughout wards and departments. Staff were observed following current infection prevention and control guidelines such as the ‘bare below the elbow’ policy. Personal protective equipment such as aprons and gloves was readily available. We observed staff members...
reminding visitors to ward areas to use hand gel on entry.

Stickers were placed on equipment to inform staff at a glance that equipment had been cleaned and in most areas we visited, sharps bins which contained used items such as needles, were noted to have been signed and dated when assembled.

Infection prevention formed part of the Trusts mandatory training programme. The compliance summary for the division of surgery showed at the time of our inspection 91% of staff had completed Infection Control Level 1 training and 77% had completed Infection Control Level 2 training against a target of 95%.

Telephone advice was available from the infection prevention and control team seven days per week. Patients were screened for methicillin resistant staphylococcus aureus (MRSA) as part of the pre-operative assessment process.

Surgical site infection rates following hip replacements and repair of neck of femur were reported on by Public Health England. The latest report in August 2017 showed two infections were reported in both 2015 and 2016 for total hip replacement 1.6% and 1.4% respectively. For repair of neck of femur there were no infections reported in 2015 and one infection in 2016 0% and 1.4% respectively.

Infection prevention and control audits were completed within the surgical division and results between January and February ranged from 77% to 83%. Improvement plans were produced and included actions and monitoring of progress.

**Environment and equipment**

The environment in main theatres was displaying signs of wear and tear. Theatre lights in theatre 9 showed visible corrosion. This was recorded as a risk on the risk register and managers advised a replacement programme was planned for theatres 7 and 9.

At the time of our inspection the theatre recovery area was being used to care for day surgery patients until they were ready for discharge. Once dressed patients were then transferred back to the surgical elective admissions lounge (SEAL) for completion of discharge paperwork and to receive any discharge medication. Between 2 January 2018 and 28 March 2018 880 patients were discharged from SEAL. Staff and managers told us this was because the day surgery unit was in use as an inpatient medical ward due to bed pressures.

We raised concerns with staff and managers due to the lack of appropriate facilities for recovered patients within the recovery area and managers acknowledged this was inappropriate. One toilet was available for patients to use, this was some distance from the main recovery area and did not have a working call bell. Drinks and toast were supplied to patients to ensure they had something to eat and drink when recovered however these items were prepared in the staff kitchen and were served using disposable cups and paper towels due to a lack of plates. By the final day of our inspection the day unit had resumed accepting post-operative day surgery patients.

Between 1 October 2017 and 28 March 2018 five incidents were recorded of patients being discharged home directly from theatre recovery. A further four incidents described inpatients
being nursed in recovery due to a lack of beds within the hospital including one critical care patient and three medical patients.

During our inspection we reviewed the environment on ward 17. This was an inpatient ward that provided care for colorectal patients. Some patients in this ward were required to stay for long periods of time and receive nutrition intravenously. On review we noted the ward was old and displaying signs of wear and tear. For example, a shower room had visible black marks on the ceiling and floor and an area of flooring in the staff kitchen required repairing which could be a potential trip hazard and also difficult to keep clean. This staff kitchen was left unlocked and at the time of the inspection was propped open which meant the hazard was also a risk for the patient and the public. We observed a sluice room containing cleaning fluid with a keypad lock which was left open and a second open sluice room with no keypad lock which contained full unlocked sharps bins and containers of antiseptic hand wash. At the time of our inspection there were four showers available for 30 patients. A further shower room was out of use and had been so for over 12 months. Managers told us that refurbishment had been planned however another area of the hospital had been chosen instead. Remedial work had also been planned but this had not progressed. A Healthwatch report following a ward visit in November 2017 had highlighted that the ward would benefit from refurbishment.

Piped oxygen and wall mounted suction was not available to all beds. In the six bedded bays oxygen could be delivered to four patients at a time and suction to two patients. In the four bedded bay, oxygen could be delivered to all patients and suction to two patients. We raised this as a concern during our inspection. Managers advised that portable oxygen and suction was available and any unwell or postoperative patients were positioned with access to the piped oxygen and wall mounted suction.

In addition, electrical extension cables were in use due to the lack of available electrical sockets and portable heaters were distributed throughout the ward to help keep the ward warm. Staff and patients told us that the temperature in the ward fluctuated significantly depending on the weather and the time of day. We raised concerns about safety regarding the use of electrical extension cables and portable heaters as we observed a heater in one side room positioned very close to bedding. We also observed electrical extension cables draped over the back of beds. We raised both risks with the trust and a risk assessment was completed while we were onsite in relation to the use of portable heaters. This was rated as a low risk.

We requested any other risk assessments completed regarding the environment on ward 17 and received a risk assessment and action plan in relation to the general environment, toilet facilities and oxygen and suction points completed following our inspection. The risk assessment stated that ‘the general ward environment is not fit for purpose, which leads to poor patient experience and low staff morale’. It also described one of the shower rooms as ‘mouldy and has a stained wall’, ward areas where there was missing floor edging in corridors and areas where ‘hand wash basins are cracked and stained making effective cleaning difficult’. Actions identified included ensuring the ward had the right amount of extension leads, a risk assessment of the usage of extension leads to be performed as per policy and scoping out the possibility of relocating the ward elsewhere in the hospital. Timelines were detailed in the action plan to support prompt action.

Between 1 October 2017 and 28 March 2018 four incidents had been reported relating to the environment on ward 17 however at the time of our inspection the environment on ward 17 was
not documented as a risk on the divisional risk register.

Safety testing was in place for equipment and documents requested from the trust confirmed an annual ventilation inspection had taken place in all theatres within the hospital.

Emergency resuscitation equipment was in place, trolleys we reviewed were visibly clean and daily checklists completed. Resuscitation trolleys were not sealed or tagged in any area we visited. This meant that in the inner waiting room of the surgical elective admissions lounge, patients and visitors to the area could potentially access the trolley as staff were not always present in this area. This was important as there was a risk that essential equipment required for an emergency may have been missing.

Bariatric theatre tables were available for patients with a high body mass index (BMI).

Assessing and responding to patient risk

Records we reviewed indicated that the condition of patients was monitored and deterioration was appropriately escalated for medical review to ensure appropriate care and treatment. Machines were in use that allowed patient observations to be automatically uploaded to the electronic patient record (EPR). This meant that information was immediately available to any clinician accessing the electronic patient record.

Sepsis rates were monitored in the surgical division and between April 2017 and March 2018 a rate of 1.8% was recorded. Sepsis is the reaction to an infection when the body attacks its own organs and tissues and is a potentially life-threatening condition.

The Malnutrition Universal Screening Tool (MUST) provides an assessment of a patient’s nutritional status on admission and assesses nutritional risk. We observed this tool completed in all of the records we reviewed. Staff told us that any patient considered at risk following completion of the MUST assessment would be referred to a dietician.

Any patient with a planned elective surgical procedure routinely attended an appointment for a preoperative assessment. This identified risks prior to surgery and included lifestyle information and assessment of any existing medical conditions as well as pre-operative infection screening. Any patient who did not proceed to surgery within six months required the full assessment process to be repeated. Information regarding primary risks and co-existing conditions was communicated electronically to the anaesthetist and medical staff via the electronic patient record and discussed with theatre staff preoperatively. Any patient found to be high risk following assessment would be required to have a further anaesthetic assessment with an anaesthetist before admission.

All patient notes were reviewed by staff in the surgical elective admissions unit (SEAL) the day before admission to ensure all pre-operative investigations and treatment had been completed. If any further treatment was required staff would arrange for the patient to attend SEAL that afternoon.

During our inspection we observed theatre processes including implementation of the World Health Organisation (WHO) Surgical Safety Checklist Five Steps to Safer Surgery. We followed a patient through the surgical pathway and observed comprehensive completion of the checklist.
This was recorded electronically however the process had not been not audited since the introduction of the electronic system the previous year. Managers told us observational audits had taken place. We requested information to support this from the trust however this was not received.

Current standards from the Association for Perioperative Practice (AfPP) state that at least one member of staff on duty in the theatre recovery area should have completed advanced life support (ALS) training. Data from the trust indicated that none of the 68 staff had received advance life support training. The trust advised this was not a training requirement for recovery staff.

At our last inspection we found only nine staff in theatre and theatre recovery had received paediatric life support training (PILS). Managers told us that training had been arranged and at the time of our inspection 44 from a total of 59 eligible staff in theatre and anaesthetics at Arrowe Park Hospital had received PILS training.

**Nurse staffing**

The trust has reported their staffing numbers below in March and October 2017. Arrowe Park Hospital had an establishment rate of 97% in March and 92.9% in October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>Time period</th>
<th>Actual WTE Staff in post</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrowe Park Hospital</td>
<td>March 2017</td>
<td>290.2</td>
<td>299.1</td>
</tr>
<tr>
<td></td>
<td>October 2017</td>
<td>274.3</td>
<td>295.3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The service did not have the correct number of suitably qualified staff.

The expected and actual staffing levels were displayed on information boards at the entrance to inpatient wards in the surgical division.

In the six months prior to our inspection the average number of shifts filled as planned, known as fill rate, for registered nurses on the surgical wards at Arrowe Park Hospital ranged from 75.4% to 109% for day shifts and 58.8% to 98.9% for night shifts.

The fill rate of 75.4% for day shifts related to ward 18 for January 2018 and February 2018. The 58.8% fill rate for night shifts related to ward 17 in November 2017.

The average fill rate for care staff ranged from 59.6% to 110.9% for day shifts and from 60% to 116.1% for night shifts.

The fill rate of 59.6% for day shifts and 60% for night shifts both related to ward 17 in November 2017.

In the six months prior to our inspection the average fill rate for registered nurses on the trauma and orthopaedic wards at Arrowe Park Hospital ranged from 68.4% to 93.6% for day shifts and 76.9% to 100% for night shifts.
The fill rate of 68.4% for day shifts related to ward 12 in December 2017 and 76.9% fill rate for night shifts related to ward 11 in September 2017.

The average fill rate for care staff ranged from 65.5% to 109.4% for day shifts and 70% to 131.1% for night shifts.

The fill rate of 65.5% for day shifts related to ward 12 in December 2017 and the fill rate of 70% for night shifts ward 12 in September 2017. Following the suspension of elective orthopaedic surgery in January 2018 ward 12 began taking medical instead of surgical patients.

The average occupancy rate between September 2017 and February 2018 across surgical, trauma and orthopaedic wards was 84.3%. Occupancy rates ranged from 75.3% in September 2017 to 91.1% in February 2018.

Managers in all areas we visited described staffing as a challenge. However, staffing, with the exception of theatres and seven unplanned beds on ward 14 covered by staff from the surgical nursing establishment, was not recorded as a risk on the surgical divisional risk register. Matrons and senior ward staff attended a daily staffing meeting at 9am each morning to complete a 24-hour staffing plan. A further night staffing plan was prepared at a meeting held at 4pm. This was to help ensure that wards were staffed safely.

We reviewed staffing rotas for February 2018 for inpatient wards across the surgical division. Staff we spoke with told us that gaps in shifts were often filled with bank staff or existing staff working additional hours. Managers advised they would use additional healthcare assistants (HCA) if registered nurses were not available.

On ward 17 staff shortages were reported to be difficult to fill due to the competencies required when caring for patients receiving intravenous nutrition and with peripherally inserted central catheters (PICC lines). A staffing action plan had been developed by senior managers to address staffing issues on the ward. These included liaising with pharmacy to identify if any intravenous antibiotics could be pre-made to reduce time spent completing this task on the ward and liaising with nursing agencies to pre-book shifts. Rotas we reviewed showed on ward 17 between 1 February and 28 February 2018 from a total of 84 shifts, 34 did not have the recommended number of staff and between 1 March and 8 March 14 shifts from a total of 24 did not have the recommended number of staff. At the time of our inspection recruitment was in progress across the surgical division.

Staff told us that issues related to staffing were reported as incidents. Between 1 October 2017 and 28 March 2018 there were 112 incidents directly reported as ward staffing incidents however a number of other incidents categorised as inappropriate transfer or inappropriate placement of patient cited staffing within the description of the incident. This included both staff numbers and the lack of suitably qualified staff.

Nurse handovers occurred at the change of each shift. We observed a comprehensive nurse handover on ward 18. Details of patient’s name, age, diagnosis, investigations, past medical history, allergies, medications, plan of care and social circumstances were discussed as appropriate.

Co-ordinators in theatres told us that staffing in the months preceding the inspection had been a challenge however the situation had improved at the time of our inspection. Between 1 October 2017 and 28 March 2018 there were 14 incidents reported in relation to staffing, of which four
specifically related to medical staffing. Theatre staffing was recorded as a risk on the divisional risk register with particular reference to orthopaedic, gynaecology, general emergency and robotic theatre and anaesthetics. Mitigation in place included management of theatre lists to ensure multiple complex cases were not listed at the same time, use of theatre staff across sites within the trust, use of agency staff and ongoing recruitment. A recent review of the risk was documented and a further review date was scheduled.

Vacancy rates

From November 2016 to October 2017, the trust reported a vacancy rate for nursing staff in surgery at Arrowe Park Hospital of 4.8%. The trust did not have a target vacancy rate.

The five services with the highest vacancy rates at Arrowe Park Hospital were:

- General Surgery – Upper G.I Service - 46.0%
- Anaesthetics & Theatres - 7, 8 &9 Ortho – 45.5%
- Anaesthetics & Theatres - 1, 2 & Day – 26.0%
- Anaesthetics & Theatres – 6, Urology – 25.3%
- Trauma and orthopaedics – Ward 10 – 18.2%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From November 2016 to October 2017, Arrowe Park Hospital reported a turnover rate of 12.9% for nursing staff in surgery. The trust target of 10% or less was not met.

At Arrowe Park Hospital 13 services had turnover rates higher than the trust target of 10%. The service with the highest number of whole time equivalent (WTE) staff members leaving was Trauma and Orthopaedics – Ward 10 (5.9), followed by General Surgery – SAU (5.1) and General Surgery – SEAL Unit (3.5).

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From November 2016 to October 2017, Arrowe Park Hospital reported a sickness rate of 5.6% in surgery this was higher than the trust target of 4%.

Sixteen of the 31 units at Arrowe Park Hospital did not meet the trust target of 4%. General Surgery – Vascular Services had the highest sickness rate of 48.4%, followed by General Surgery – Oral and Maxillofacial with 19.2%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and agency staff usage

From November 2016 to October 2017, Arrowe Park Hospital reported 1,674 shifts filled by bank staff (1.7%) and 150 (0.1%) shifts filled by agency staff in surgery. There were 1,193 shifts not filled by bank or agency staff (1.2%).

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>1,310 (3.2%)</td>
<td>364 (0.6%)</td>
<td>1,674 (1.7%)</td>
</tr>
<tr>
<td>Agency</td>
<td>0 (0%)</td>
<td>150 (0.3%)</td>
<td>150 (0.1%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>743 (1.8%)</td>
<td>450 (0.8%)</td>
<td>1,193 (1.2%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

The trust reported their staffing numbers below in March and October 2017. Arrowe Park Hospital had an establishment of 67.6% in March and 64.9% in October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>Time period</th>
<th>Actual WTE Staff in post</th>
<th>Planned WTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrowe Park Hospital</td>
<td>March 2017</td>
<td>144.0</td>
<td>213.0</td>
</tr>
<tr>
<td></td>
<td>October 2017</td>
<td>138.8</td>
<td>214.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From November 2016 to October 2017, Arrowe Park Hospital reported a vacancy rate of 35.0% for medical and dental staff in surgery;

The five services with the highest vacancy rates at Arrowe Park Hospital were:

- Special Surgery – Oral and Maxillofacial – 70.5%
- General surgery - Vascular Services – 54.2%
- Anaesthetics & Theatres - Anaesthetics Office – 40.9%
- Special surgery – General Ophthalmology – 40.1%
- Special Surgery – General E.N.T – 38.0%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
### Turnover rates

From November 2016 to October 2017 Arrowe Park Hospital reported a turnover rate of 20.2% for medical and dental staff in surgery. This is much higher than the trust target of 10%.

Eight services had a turnover rate higher than the trust target of 10%. The services with the highest number of WTE staff members leaving the trust were Anaesthetics & Theatres – Anaesthetics Office (9.6) and Trauma and Orthopaedics – T&O Support (6.0).

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

### Sickness rates

From November 2016 to October 2017, Arrowe Park Hospital reported a sickness rate of 1.2% for medical and dental staff in surgery. This is much better than the trust target of 4%.

Eight of the ten units had a sickness rate below 1%, while Special Surgery – General ENT had a rate of 5.6% and Trauma and Orthopaedics – T&O Support had a rate of 3.2%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

### Bank and locum staff usage

From November 2016 to October 2017, Arrowe Park Hospital reported 673 shifts filled by bank staff and 1301 shifts filled by locum staff in surgery. There were 51 shifts not filled by either bank or locum staff.

A breakdown of bank and locum usage by staff type at Arrowe Park Hospital is shown below. Please note that the trust did not provide the total shifts available for middle grade doctors so we are unable to calculate bank and locum usage overall or for this staff type as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Consultant</th>
<th>Middle grade</th>
<th>Doctor in training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>12</td>
<td>46</td>
<td>615</td>
<td>673</td>
</tr>
<tr>
<td>Locum</td>
<td>279</td>
<td>839</td>
<td>183</td>
<td>1,301</td>
</tr>
<tr>
<td>Not filled</td>
<td>13</td>
<td>32</td>
<td>6</td>
<td>51</td>
</tr>
</tbody>
</table>

No medical bank or locum usage was reported at Clatterbridge Hospital.

### Staffing skill mix

As at October 2017, the proportions of consultant and junior (foundation year 1-2) staff reported to be working in surgery at the trust were higher than the England averages.
Staffing skill mix for the whole time equivalent staff working at Wirral University Teaching Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>55%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>19%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>17%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ 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)

The service had the correct number of suitably qualified staff. We reviewed medical rotas for the two months prior to our inspection.

Locum staff were used to fill any gaps in the rotas and the orthopaedic and surgical rotas were supported by advanced nurse practitioners (ANPs).

We observed a medical ward round on ward 18 following a multi-disciplinary meeting and saw the plan of care discussed with the involvement of the patient. Additional ward rounds observed did not have a ward nurse present and staff reported nursing staff were not always verbally told of the outcome of a ward round, however this was always documented in the electronic patient record.

Out of hours there were processes in place for consultant cover. The non-resident consultant on call for trauma and orthopaedics ran from 8pm to 8am on weekday nights and throughout the weekend. For surgery there was one non-resident consultant on call from 1pm one day to 1pm the next. All consultants were contactable if not on site. Surgical assessment unit (SAU) consultant cover was provided Monday-Friday 8am-5pm and 8.30-1pm at weekends. Junior medical staff told us they felt supported and received weekly protected teaching sessions.
Records

Paper patient records were securely stored in locked trolleys in most of the areas we visited. However, we observed two unlocked, unattended record trolleys on ward 20 and highlighted this to staff.

Most patient records were electronic (EPR). Paper records in use were those that preceded the introduction of the EPR and current consent forms for surgical procedures and ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) documentation.

We looked at 17 sets of patient records. Risk assessments using the Malnutrition Universal Screening Tool, venous thromboembolism (VTE) assessments and Early Warning Scores used to record observations and identify signs of deterioration were completed correctly in all 17 records. We observed one DNACPR form brought into hospital with patient in the records however this was not documented on the patient’s EPR or highlighted at staff handover. This was raised with staff and we subsequently observed the DNACPR status recorded on the patient’s electronic record.

Medicines

Medicines were stored securely in locked cupboards or refrigerators, as appropriate, and in line with legislation and daily pharmacy support was available. Controlled drugs were stored securely and accurate records maintained in accordance with trust policy.

Temperature readings of refrigerators that store medicines and vaccines should be between two and eight degrees and any deviations and corrective action should be recorded. Documentation we reviewed indicated fridge temperature readings were not consistently recorded across the surgical division. We observed records in theatre that showed between 7 January 2018 and the time of our inspection refrigerator temperatures had not been recorded on seven occasions and on ward 18 in January 2018 refrigerator temperatures had not been recorded on eighteen occasions.

Prescriptions were completed electronically and of the 14 prescription charts reviewed all had allergies documented, venous thromboembolism prophylaxis if indicated and no medication delayed or omitted without an appropriate reason.

Staff were observed wearing red disposable tabards with the message ‘do not disturb medicine round in progress’ when conducting drug rounds to alert patients and other staff and so limit distractions.

We observed medication administration for three patients; on each occasion the nurse checked the patient’s identity. The nurse had a good rapport with all patients and took the time necessary to support them to take their medication.

We observed the medicines management pharmacy technician (MMT) initiate the medicines reconciliation process for a patient. This was within the national guidelines standard of 24hrs. The MMT completed a medication locker check and spoke to the patient to obtain an appropriate medication history.

Antimicrobial Stewardship was reviewed. The electronic medical record had recently been updated to include an antimicrobial stewardship section and we were told this would support the prescribing module to include indication in the future.
Incidents
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 January 2017 to December 2017, the trust reported two incidents classified as a never events for surgery.

The first incident took place in February 2017 at Arrowe Park Hospital Ophthalmology Clinic and involved the wrong patient receiving laser treatment. This was due to two patients attending the clinic with the same name. The patient who received the wrong treatment was contacted and the correct patient underwent appropriate treatment.

The second never event occurred in June 2017 and related to a piece of a drill bit being left inside a patient. The consultant checked the x-ray post operation and confirmed that some of the drill bit was embedded in the hip joint. The patient was made aware of this and the Consultant made the decision to take no further action as there was no adverse outcome for the patient.

(Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017))

We reviewed the root cause analysis investigation report for both never events and found lessons learned were identified in both cases and action plans initiated to reduce the likelihood of incidents being repeated.

At the time of our inspection senior managers advised that a further never event had occurred in the surgical division in February 2018. This related to the administration of the drug methotrexate. We reviewed the initial 72 hour review report which detailed initial findings, immediate and further actions and decision to proceed to a root cause analysis investigation. This is a more in depth investigation to identify any learning.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 17 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with seven (41% of total incidents).
- Slips/trips/falls meeting SI criteria with five (29% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with four (24% of total incidents).
- VTE meeting SI criteria with one (6% of total incidents).
Incidents were reported using an electronic system however incident reporting was variable across the surgical division. Staff gave examples of occasions where they had experienced low staff numbers and an inappropriate transfer of a patient that had not been reported as an incident.

Staff were aware of the types of incidents they would report. Lessons learnt from incidents were shared with staff in weekly bulletins sent electronically and discussed in team meetings and safety huddles. However not all staff we spoke with were aware of the never events that had occurred within the division and locum staff reported poor access to trust email accounts to access the learning that was shared electronically.

Between 1 October 2017 and 28 March 2018 there were 788 incidents and 13 serious incidents reported in the surgical division. Monthly incident trend reports were produced and displayed in ward areas. Information included the number of staffing, medicine management and safeguarding incidents reported.

Weekly safety summits were held which were open to all staff. This provided a forum for incidents to be discussed including initial learning, long term solutions and any impact on the patient.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with were aware of the term and the principle behind the regulation.

Monthly mortality review meetings took place within surgical specialities to review deaths and enable lessons to be learnt and highlight areas for improvement.

**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 21 new pressure ulcers, four falls with harm and 16 new catheter urinary tract infections from December 2016 to December 2017 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Wirral University Teaching Hospital NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Total Pressure ulcers (21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Falls (4)</td>
</tr>
<tr>
<td>Total CUTIs (16)</td>
</tr>
</tbody>
</table>

In December 2016, surgery reported three pressure ulcers. Performance against this metric improved over the next seven months; however the trust reported five pressure ulcers in October 2017 and a further seven in December 2017.

Four falls were reported, three in November and one in December 2017, possibly due to winter pressures.

A total of 16 new urinary tract infections in patients with a catheter were reported over the period December 2016 to December 2017. Trust performance declined in the first four months with the trust reporting four new urinary tract infections in April 2017. Although there was an improvement from May to November 2017, the trust reported three new urinary tract infections during the winter month of December 2017.

*(Source: NHS Digital)*
Safety thermometer information was displayed on 'Proud to Care' posters in each ward. Information included the number of MRSA infections, Clostridium Difficile infections, pressure ulcers or falls that had occurred in the area within a defined month. In response to an increased number of pressure ulcers recorded a weekly monitoring tool was to be trialled on ward 10. With regard to falls a local monitoring tool was to be trialled on the orthopaedic wards and a thematic review of the locations of falls was planned to inform further actions.

Is the service effective?

Evidence-based care and treatment

Staff could describe the use of evidence based guidance that underpinned care for example when assessing nutritional status or pressure ulcer care. Compliance with National Institute for Health and Care Excellence (NICE) guidance was a standing agenda item on the bimonthly divisional clinical governance report.

The surgical division contributed to a number of national audits such as the Hip Fracture Audit and the National Emergency Laparotomy Audit. A divisional audit programme was in place and included an audit of fasting times for surgical patients and the correct application of Thrombo-Embolic Deterrent (TED) stockings. TED stockings are used to help prevent the occurrence of blood clots developing in the leg after surgery.

Managers told us that introduction of National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs) were well advanced and we reviewed an example of a LocSSIP in use within ophthalmology.

The World Health Organisation (WHO) Surgical Safety Checklist Five Steps to Safer Surgery was used in theatre and recorded electronically. Staff advised that the checklist had been adapted for local need with the addition of specialty specific questions.

Nutrition and hydration

During admission patient’s nutritional status was assessed using the Malnutrition Universal Screening Tool. Any patient identified as malnourished or at risk of malnutrition was referred to the dietetic service. Referral was completed electronically and staff reported this resulted in a prompt response.

We observed records of monitoring of fluid intake within electronic patient records (EPR). A range of meal options were available for patients and those we spoke with described the food as 'ok' however ‘presentation is not good’.

Different coloured trays were in use to highlight any patients that may require assistance with meals.

Pain relief

Pain was assessed using a verbal scoring system. Patients told us their pain was managed and they had received regular pain relieving medication which was brought promptly when requested. The acute pain team were available to assist patients identified as requiring additional support.
following surgery such as epidurals and patient controlled analgesia.

An external review of the pain service completed in February 2017 identified that the service should have two whole time equivalent (WTE) acute pain nurses. There was one pain nurse in post at the time of our inspection who was available Monday to Friday 9am-5pm. Lack of adequate specialist pain nurses was documented as a risk on the divisional risk register and a further staff member had been recruited. A plan was in place to develop the service to cover Monday to Saturday when the new staff member was in post. The acute pain service was covered by maternity anaesthetists out of hours.

**Patient outcomes**

Patient outcomes were monitored in divisional mortality and morbidity meetings and clinical governance meetings and an internal audit programme was in place.

The deputy associate director of nursing and allied health professionals in theatre was the chair of the North West Theatre Network at the time of our inspection and described work that was in progress to benchmark the service and share best practice. Examples included discussion of incidents and root cause investigation analysis at regional level to share lessons learned.

**Relative risk of readmission**

**Trust level**

From October 2016 to September 2017, patients at the trust had a similar too expected risk of readmission for elective admissions when compared to the England average.

- Urology patients had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Colorectal Surgery and Trauma & Orthopaedics patients had similar to expected risks of readmission for elective admissions when compared to the England averages.

**Elective Admissions – Trust Level**

![Graph showing Elective Admissions – Trust Level](image)

*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 is represents the opposite. Top three specialties for specific trust based on count of activity*

Patients at the trust had a similar expected risk of readmission for non-elective admissions when compared to the England average.
• General Surgery patients had a similar too expected risk of readmission for non-elective admissions when compared to the England average.
• Urology and Trauma & Orthopaedics patients had slightly lower than expected risks of readmission for non-elective admissions when compared to the England averages.

Non-Elective Admissions – Trust Level

Non-Elective Admissions

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 is represents the opposite. Top three specialties for specific trust based on count of activity
(Source: HES - Readmissions (01/10/2016 - 30/09/2017))

Arrowoe Park Hospital

From October 2016 to September 2017, patients at Arrowoe Park Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

• Colorectal Surgery patients had a similar too expected risk of readmission for elective admissions when compared to the England average.
• Urology patients had a much higher than expected risk of readmission for elective admissions when compared to the England average.
• ENT patients had a slightly higher than expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - Arrowoe Park Hospital

Elective Admissions

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 is represents the opposite. Top three specialties for specific trust based on count of activity

Patients at Arrowoe Park Hospital had a similar too expected risk of readmission for non-elective admissions when compared to the England average.

• General Surgery patients had a similar too expected risk of readmission for non-elective admissions when compared to the England average.
• Urology and Trauma & Orthopaedics patients had slightly lower than expected risks of...
readmission for non-elective admissions when compared to the England averages.

Non-Elective Admissions - Arrowe Park 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 is represents the opposite. Top three specialties for specific trust based on count of activity
(Source: Hospital Episode Statistics)

National Hip Fracture Database

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 9.2%, which was worse than expected. The 2016 figure was 7.2%.

The proportion of patients having surgery on the day of or day after admission was 76.3%, which was worse than the national standard of 85%. The 2016 figure was 77.2%.

The perioperative medical assessment rate was 93.7%, which failed to meet the national standard of 100%. The 2016 figure was 94.9%.

The proportion of patients not developing pressure ulcers was 94.8%, which falls in the bottom 25% of trusts. The 2016 figure was 94.6%.

The crude overall length of stay was 20.1 days which falls in the middle 50% of trusts. The 2016 figure was 22.5 days.

(Source: National Hip Fracture Database 2017)

An action plan was in progress following the 2017 Hip Fracture Audit. Managers told us the Wirral Acute Femoral Fracture Unit (WAFFU) had been opened as a direct response. The unit was open at the time of our inspection however was not performing as planned until the resumption of elective orthopaedic surgery. Criteria for admission to the unit had been developed to identify appropriate patients with an acute fractured neck of femur.

National Bowel Cancer Audit

In the 2017 National Bowel Cancer Audit, 82.4% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 65.5%.

The risk-adjusted 90-day post-operative mortality rate was 1.6% which was within the expected range. The 2016 figure was 1.1%.
The risk-adjusted 2-year post-operative mortality rate was 21.7% which within the expected range. The 2016 figure was 16.6%.

The risk-adjusted 30-day unplanned readmission rate was 5.9% which was within the expected range. The 2016 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 40.2% which was as expected. The 2016 figure was 47.4%.

The trust had a case ascertainment rate of 119.5%, indicating trust involvement in this audit was good.

(Source: National Bowel Cancer Audit)

National Vascular Registry 2017

The trust did not participate in this audit.

(Source: National Vascular Registry)

National Oesophago-Gastric Cancer Audit

In the 2016 National Oesophago-Gastric Cancer Audit, the age and sex adjusted proportion of patients diagnosed after an emergency admission was 26.1%, worse than the national aggregate of 13.7%. Patients diagnosed after an emergency admission are less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 22%.

At strategic clinical network level, the crude proportions of patients treated with curative intend was 45%, significantly better than the national aggregate of 37.6%.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

In the 2017 National Emergency Laparotomy Audit (NELA), Arrowe Park Hospital achieved a yellow rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 230 cases.

Arrowe Park hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 188 cases.

Arrowe Park Hospital achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 140 cases.

Arrowe Park Hospital achieved a yellow rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 87 cases.
The risk-adjusted 30-day mortality rate for Arrow Park Hospital was within the expected range, based on 230 cases.
(Source: National Emergency Laparotomy 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.

![Graph showing patient reported outcomes](image)

In 2016/17 performance on groin hernias was generally poorer than the England average. Trust performance improved by 35% for EQ VAS while England improved by 39%. The EQ-5D Index improved by 38% at the trust and England improved by 50%.

Due to small numbers, the percentage improvement at the trust in relation to hip replacements could not be published.

For knee replacements, the trust scores were similar to the England average. Trust performance for EQ VAS improved by 55% while England improved by 57%. The EQ-5D Index for the trust improved by 79% and England scores improved by 81%. In the Oxford Knee Score, the trust performance improved by 94% which was the same as the percentage for England.

For Varicose Veins, trust performance improved for the Aberdeen Varicose Vein Questionnaire by 75%, while England improved by 81%. The EQ VAS Index at the trust improved by 39% and the England score improved by 40%. The trust only had a small number of cases to rate the EQ-5D Index and so percentage improvement is not available.

(Source: NHS Digital)
Competent staff

Appraisal rates

Arrowe Park Hospital:

From April 2017 to October 2017, 40.7% of staff within surgery at Arrowe Park Hospital had received an appraisal compared to a trust target of 88%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals completed</th>
<th>Eligible staff</th>
<th>Appraisal rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>9</td>
<td>15</td>
<td>60.0%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff</td>
<td>24</td>
<td>50</td>
<td>48.0%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>19</td>
<td>43</td>
<td>44.2%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>145</td>
<td>329</td>
<td>44.1%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>130</td>
<td>297</td>
<td>43.8%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>2</td>
<td>5</td>
<td>40.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>32</td>
<td>144</td>
<td>22.2%</td>
<td>No</td>
</tr>
<tr>
<td>Public Health &amp; Community Health Services</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff identified their learning needs through the trusts appraisal process. Staff we spoke with reported receiving annual appraisals and described opportunities for development in their role. Further information regarding compliance was obtained at the time of our inspection. The mandatory training compliance report for February 2018 for the surgical division indicated appraisal rates were 87% compared to a target of 88%. Appraisal compliance per staff group was 96% for medical and dental staff and 84% for nursing and midwifery registered staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th># compliant</th>
<th>% Compliant</th>
<th># Non compliant</th>
<th>% Non compliant</th>
<th>Total Staff</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>134</td>
<td>96%</td>
<td>5</td>
<td>4%</td>
<td>139</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>357</td>
<td>84%</td>
<td>69</td>
<td>16%</td>
<td>426</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>491</td>
<td>87%</td>
<td>74</td>
<td>13%</td>
<td>565</td>
<td>No</td>
</tr>
</tbody>
</table>

Preceptorship was in place for newly qualified staff and included attendance at a development week facilitated by staff from the clinical skills laboratory. Staff received documentation to bring back to their area of work to document competencies achieved which was then reviewed after 6 months in post.
We observed formal competency documentation in use in the surgical elective admissions lounge (SEAL) for activities such as intravenous cannulation and completing electrocardiographs (ECG). Assessment involved direct observation of practice following attendance at the clinical skills centre with activities being performed a set number of times under supervision.

Managers on ward 18 also described competencies for the care of patients with tracheostomies however there was no documentation available to support this.

A range of competencies were required and assessed in theatres. These included role specific competencies for recovery staff, scrub practitioners and staff undertaking the dual role of scrub practitioner and surgical first assistant at the same time.

Junior medical staff reported they felt supported.

Managers described how they dealt with poor performance in their teams. This included discussion of any welfare issues as well as assessment of training needs and reference to the Performance and Capability policy.

**Multidisciplinary working**

Daily multi-disciplinary team (MDT) meetings took place on ward 11 including weekends and any patient admitted with a fractured neck of femur also received care from an ortho-geriatrician.

We observed a number of positive examples of multi-disciplinary team (MDT) working during our inspection both on wards and in theatre. One example involved a meeting with the nutritional support team, clinical lead, pharmacist, dietitian and microbiologist that demonstrated a comprehensive and holistic approach to patient care.

Records we reviewed indicated evidence of multi-disciplinary team work where appropriate however we observed nurses were not present on daily ward rounds.

**Seven-day services**

Emergency theatres were available 24 hours a day. Physiotherapy services were available daily including at weekends to care for patients assessed as a priority. Daily pharmacy support was available and pharmacists attended discharge ward rounds at weekends to facilitate the provision of medicines to take home. The chaplaincy provided 24 hour spiritual care if required.

**Health Promotion**

Lifestyle information was discussed with patients who attended for pre-operative health assessment and included smoking and alcohol intake.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

Planned surgical procedures were discussed and consent obtained during outpatient clinic consultations. Consent was then confirmed by medical staff on the day of procedure when the
patient attended the surgical elective assessment unit (SEAL) in line with best practice.

Staff described how they would deal with patients if concerns were raised regarding capacity including escalation to medical staff, involvement of family members and referral to the safeguarding team.

Staff could describe the process of assessing capacity and the requirements for obtaining consent if the patient was assessed as lacking capacity. We reviewed five completed consent forms, three for patients with capacity and two for patients without capacity. In the records where patients lacked capacity one had a documented discussion with a family member, the second record had no documented discussion or involvement of family members or an Independent Mental Health Advocate (IMCA).

We reviewed four records of patients subject to a Deprivation of Liberty Safeguards (DOLS) order. The Mental Capacity Act 2005 allows restraint and restriction to be used if they are in a person’s best interest. Extra safeguards (Deprivation of Liberty Safeguards) are needed if restriction and restraint used will deprive a person of their liberty. Three of the four records had a documented assessment of capacity, however as the trust process required a referral to the safeguarding department to initiate the application this resulted in a subsequent delay in submission of the DOLS application. This is important as an application should be made to the lawful authority as soon as a restriction is put in place. Following our inspection this was added as a risk on the corporate risk register.

**Mental Capacity Act and Deprivation of Liberty training completion**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust reported that their Protecting Vulnerable People (PVP) courses contain modules relating to the Mental Capacity Act (MCA), Deprivation of Liberty safeguards (DoLS) and Mental Health Act training. Data on the individual modules within these courses was not provided.

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

**Arrowe Park Hospital:**

The breakdown of PVP training completion from April 2017 to October 2017 for nursing staff in surgery at Arrowe Park Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>180</td>
<td>293</td>
<td>61.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 3</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 1</td>
<td>0</td>
<td>3</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for PVP courses by nursing staff in surgery at Arrowe Park Hospital was 60.6%. Nursing staff did not meet the trust target for any of the three PVP courses.
The breakdown of training completion from April 2017 to October 2017 for medical staff in surgery at the trust is shown below. All of the staff were based at Arrowe Park Hospital.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>62</td>
<td>143</td>
<td>43.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 1</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for PVP courses by medical and dental staff in surgery at the trust was 43.1%. Medical and dental staff did not meet the trust target for either of the two PVP courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Training on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) was incorporated in mandatory safeguarding training. Further information regarding mandatory training compliance was obtained at the time of our inspection. The mandatory training compliance report for February 2018 for the surgical division showed 91% of staff were compliant with consent training.

Is the service caring?

Compassionate care

Male and female lounges were situated in the surgical elective assessment lounge (SEAL) to ensure the privacy and dignity of patients who were dressed in hospital gowns awaiting theatre. A notice was displayed advising patients that a chaperone was available for consultations on request.

During our inspection patients we spoke to were positive regarding the care they had received describing the staff as ‘lovely’, ‘kind’, ‘brilliant’ and ‘caring’, stating they couldn't fault them.

We observed staff interacting with patients treating them with kindness and respect. One interaction involved a porter transferring a patient to a ward on a bed. The staff member was observed explaining the route to the patient and advising of any bumps that may cause alarm or discomfort. Another involved a patient with learning disabilities who was being walked from SEAL to theatre accompanied by their carer.

We also observed positive interactions between staff who were willing to assist each other with tasks despite high levels of activity in the department.

Friends and Family test performance

From December 2016 to November 2017, the Friends and Family Test response rate for surgery at Arrowe Park Hospital was 18% which was worse than the England average of 29%.
Recommendation rates at Arrowe Park Hospital ranged from 80% to 100%, across all wards and services. Results must be interpreted taking the low response rates into account, which could influence the validity of the figures.

*(Data only includes Wards with total responses above 100; Top 12 wards shown per site)*

(Source: NHS England Friends and Family Test)

Friends and family tests results were displayed in areas we visited.

**Emotional support**

Carers of patients with special needs were encouraged to stay throughout admission and accompany the patient to theatre to provide emotional support.

Staff in theatre described the care of a patient with mental health issues. To improve the experience for the patient and promote acceptance of treatment the same practitioners cared for the patient each time they attended for surgery over a six month period and made contact by telephone after the procedure when discharged home.

We observed information given to patients verbally and in written format regarding their condition and treatment.

Macmillan nurses were available for patients to talk to about their condition.

Spiritual care was available from the chaplaincy for patients of all faiths and included the opportunity to discuss any worries or concerns prior to surgery.

**Understanding and involvement of patients and those close to them**

Patients we spoke with stated they felt consulted regarding their treatment and had been kept informed of their plan of care. Parents were invited into the theatre recovery area to support their children.
Staff in the surgical elective admissions lounge (SEAL) and theatre described how patients who attended with additional needs were accommodated including the use of two treatment rooms for younger patients who may be accompanied by family.

We observed a patient with a hearing impairment receive medication. During the procedure the nurse had access to a language support booklet which contained some examples of helpful sign language to support communication with the patient.

Is the service responsive?

Service delivery to meet the needs of the local people

The surgical elective admissions lounge (SEAL) was a bright modern area with an inner waiting area for patients attending for ophthalmology procedures. Separate male and female lounges and toilets were available for patients awaiting theatre who were required to undress and put on a theatre gown.

At the time of our inspection the pre-operative assessment service was a combination of booked and drop in appointments, however plans were in place to trial an all drop in service. Managers advised this was to allow patients to attend for a pre-operative assessment directly after their outpatient clinic appointment and so prevent the need to return on another occasion.

Average length of stay

Trust Level – elective patients

From November 2016 to October 2017, the average length of stay for all elective patients at the trust was 3.5 days, which was slightly shorter compared to the England average of 3.9 days.

- The average length of stay for Trauma & Orthopaedics elective patients at the trust was 3.3 days, which is slightly shorter compared to the England average of 3.9 days.
- Urology elective patients at the trust had an average length of stay of 2.7 days, which is slightly longer compared to the England average of 2.5 days.
- Colorectal Surgery elective patients at the trust had an average length of stay of 7.7 days, which is slightly longer compared to the England average of 7.1 days.

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.
Trust Level – non-elective patients

The average length of stay for non-elective patients at the trust was 4.8 days, which was slightly shorter compared to the England average of 5.0 days.

- The average length of stay for General Surgery non-elective patients at the trust was 3.8 days, which is about the same as the England average of 3.9 days.
- The average length of stay for Trauma & Orthopaedics non-elective patients at the trust was 9.5 days, which is longer compared to the England average of 8.8 days.
- The average length of stay for Urology non-elective patients at the trust was 3.0 days, which is about the same as the England average of 2.9 days.

Non-Elective Average Length of Stay – Trust Level

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

Arrowe Park Hospital - elective patients

From November 2016 to October 2017 the average length of stay for elective patients at Arrowe Park Hospital was 4.1 days, which was slightly longer compared to the England average of 3.9 days.

- The average length of stay for Trauma & Orthopaedics elective patients at was 4.5 days, which is longer compared to the England average of 3.9 days.
- The average length of stay for Urology elective patients was 2.7 days, which is about the same as the England average of 2.5 days.
- The average length of stay for Colorectal Surgery elective patients was 7.8 days, which is longer compared to the England average of 7.1 days.

Elective Average Length of Stay – Arrowe Park Hospital

Note: Top three specialties for specific trust based on count of activity.
Arrowe Park Hospital - non-elective patients

The average length of stay for non-elective patients was 4.8 days, which is about the same as the England average of 5.0 days.

- The average length of stay for General Surgery non-elective patients was 3.8 days, which is about the same as the England average of 3.9 days.
- The average length of stay for Trauma & Orthopaedics non-elective patients was 9.4 days, which is slightly longer compared to the England average of 8.8 days.
- The average length of stay for Urology non-elective patients was 3.0 days, which is about the same as the England average of 2.9 days.

Non-Elective Average Length of Stay - Arrowe Park Hospital

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4.8</td>
<td>5.0</td>
</tr>
<tr>
<td>General Surgery</td>
<td>3.8</td>
<td>3.9</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>9.4</td>
<td>8.8</td>
</tr>
<tr>
<td>Urology</td>
<td>3.0</td>
<td>2.9</td>
</tr>
</tbody>
</table>

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

Meeting people’s individual needs

Staff described how people in vulnerable circumstances were accommodated in the surgical elective admissions lounge (SEAL) and theatres. Arrangements included the use of two treatment rooms in SEAL for younger patients and family or carers staying throughout admission to accompany the patient to theatre.

A chaperone policy was in place however this had been due for review in September 2017. A notice was displayed in the SEAL waiting area advising patients that a chaperone was available for consultations on request.

We observed the ‘This is me’ document in use on ward 18. The document provided staff with important additional information about a patient to enable staff to see the person as an individual and ensure care was tailored to individual needs.

Staff completed online dementia training and a dementia nurse was in post to support care planning for individual patients.

We observed the use of visual prompts to aid the delivery of care to patients in need of additional support for example with eating or due to dementia.

Limited facilities were observed for children in the theatre recovery area. A designated bay was used that could be screened off with a picture on the wall and age appropriate bed covers. Parents were invited in to the recovery area to support their children as they recovered from the anaesthetic.
Access to interpreting services could be arranged for those patients whose first language was not English. Face to face translators could be booked in advance of a patient’s attendance, alternatively interpreting services could be arranged by telephone. Sign language interpreters could be arranged to support communication for patients who were deaf or had a hearing impairment. However, we did not see either system in use during our inspection.

There was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. They were only in English but could be ordered in other languages or alternative formats if required.

Access and flow

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

From January 2017 to December 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was consistently worse than the England average.

From January to November 2017 trust performance was around 14% lower than the England average for patients who were referred for treatment. This figure improved slightly in December 2017 to 9%.

(Source: NHS England)

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

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Of these, none of the specialties were above the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>48%</td>
<td>72%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>53%</td>
<td>61%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>61%</td>
<td>72%</td>
</tr>
</tbody>
</table>

At the time of our inspection all elective orthopaedic surgery had been cancelled due to winter bed pressures.
Managers told us a process was in place to support the clinical management of patients waiting for surgery. This included discussions with clinicians on a day to day basis and no cancellation of any patients on the cancer pathway or any patients who were acutely unwell.

**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.

The percentage of patients whose operations was cancelled and not treated within 28 days improved from 7% in Q3 2015/16 to no operations being cancelled in Q2 2016/17. In Q3 2016/17 percentages escalated to 5% before improving in both Q4 2016/17 (4%) and Q1 2017/18 (2%). The percentage rose once again to 10% in Q2 2017/18.

The trust performed consistently better than the England average from Q4 2015/16 to Q1 2017/18 (January 2016 to June 2017).

**Percentage of patients whose operation was cancelled and were not treated within 28 days**

- Wirral University Teaching Hospital NHS Foundation Trust

![Graph showing the percentage of cancelled operations]

**Cancelled Operations as a percentage of elective admissions - Wirral University Teaching Hospital NHS Foundation Trust**

![Graph showing the percentage of cancelled operations]

Over the two years, the percentage of cancelled operations at the trust showed a slight increase in trend, but was generally lower than the England average. Cancelled operations as a
percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

All patients attending for elective surgery were admitted through the surgical elective admissions lounge (SEAL).

Admission to the surgical assessment unit (SAU) was from the accident and emergency department or direct GP referral. Following review patients who required surgery were either taken to theatre or discharged and returned via SEAL the next day depending on their clinical condition for further treatment or surgery.

The surgical division recorded a number of bed moves both during the day and at night. Data from the trust showed between 1 January 2018 and 28 February 2018 there were 668 bed moves during the day at Arrowe Park Hospital and 417 at night.

The Integrated Quality Governance Report for March 2018 stated that in January 2018 across the trust 33 patients living with dementia moved wards between 9pm and 7am. Patients who suffer with dementia are vulnerable and sensitive to their environment due to the nature of their condition.

Learning from complaints and concerns

Summary of complaints

From November 2016 to November 2017, there were 90 complaints about surgery across both sites. The trust took 69 days to investigate and close these complaints.

The trust has not provided details of the level of the complaints. Their complaints policy states that level 2 complaints should be closed within 25 days; level 3 complaints within 45 days; and complex level 4 complaints in 60 days.

From November 2016 to November 2017 there were 75 complaints about surgery at Arrowe Park Hospital.

The themes from the 75 complaints were:
- Patient Care – 42 complaints (56%)
- Communications – 15 complaints (20%)
- Appointments – seven complaints (9%)

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

Between December 2017 and February 2018, a further 25 complaints were received by the division of surgery at Arrowe Park Hospital. Complainants were offered face to face resolution and managers and staff told us they actively promoted verbal de-escalation to help solve concerns quickly.
Clinical governance reports for the division of surgery provided information to senior managers regarding the number and performance of complaints management as well as themes and trends.

Lessons learnt from complaints were shared in safety huddles however the service did not always investigate complaints in a timely manner as per their policy. The clinical governance report for the surgical division in January 2018 stated as of 9 January 18 there were 32 active complaints within division, 14 were within agreed timescales however 18 had breached.

We discussed complaint response times with managers who advised the response rate had deteriorated possibly due to the process being centrally managed.

We did not observe patient information leaflets about how to complain in the wards or departments we visited.

**Is the service well-led?**

**Leadership**

The divisional leadership team consisted of a divisional director, divisional medical director and an associate director of nursing who were supported by a deputy associate director of nursing and three matrons. Theatre services were led by a deputy associate director of nursing and healthcare practitioners.

Staff reported that the matrons and deputy associate directors were visible and approachable and we observed positive interactions between staff and managers. Wards and departments were led by band 7 managers supported by band 6 staff. However, a number of managers were absent due to unplanned sickness, annual leave or bereavement leave during our inspection. The band 7 manager for the Surgical Elective Admissions Lounge, day case and pre-operative assessment area covered both Arrowe Park hospital and Clatterbridge hospital sites.

Safety huddles were conducted at the beginning of each shift by the nurse in charge which allowed information to be shared with staff.

Prior to our inspection a monthly matron drop in session had commenced. This provided an opportunity for staff to raise concerns with managers away from the ward environment.

**Vision and Strategy**

The trust’s values were abbreviated to the acronym PROUD. This stood for Patient, Respect, Ownership, Unity and Dedication. Staff we spoke with were aware of the values and these were visibly displayed throughout the surgical areas in Arrowe Park hospital site.

The trust vision was ‘to be the first choice healthcare partner to the communities we serve - from the home to the provision of regional specialist centres’.

A 2017/18 strategy was in place for the surgical division which identified priorities and clear objectives however did not detail how and when progress would be measured.
Managers in theatres had a clear vision of how they planned to develop the service. This included standardising processes and a team based approach to support the development of a staff charter.

**Culture**

Staff and managers told us morale was variable dependant on workload and acuteness of patients however, all described a good team working culture at ward level. Theatre staff talked about a positive change in culture with the arrival of new staff to the department and plans to develop a staff charter.

We observed information leaflets and posters informing staff about the role of the Freedom to Speak Up Guardian. Staff knowledge of the role was variable however they told us they felt able to raise concerns with immediate managers. A Freedom to Speak Up guardian works alongside the trust’s leadership team to ensure staff have the capability to speak up effectively and are supported appropriately if they have concerns regarding patient care.

Results of the 2017 NHS Staff Survey from across the trust showed 59% of staff would recommend the organisation as a place to work compared to a national average of 61% and 69% stated if a friend or relative needed treatment, they would be happy with the standard of care provided by this organisation compared to a national average of 71%. The trust also ranked in the lowest 20% of all acute trusts for staff satisfaction with the quality of work and care they are able to deliver.

**Governance**

A governance structure was in place within the surgical division. Bi-monthly divisional clinical governance meetings took place attended by members of the divisional management team. Discussion took place regarding issues such as incidents, risks, complaints and compliance with National Institute for Health and Care Excellence (NICE) guidance. A weekly newsletter was circulated to staff that contained information regarding incidents across the trust, the outcome of the review and any lessons learned.

Safety huddles took place at the beginning of each shift and included discussion of incidents and safeguarding issues as well as the resuscitation status of patients and planned discharges, however this was not always documented on every ward we visited.

**Management of risk, issues and performance**

Corporate and divisional risk registers were in place and were discussed at divisional clinical governance and management team meetings. Managers knew the risks and mitigating actions within their departments however despite this a risk assessment relating to the use of portable heaters on ward 17 was not completed until concerns were raised during our inspection. A further full risk assessment regarding the general environment, toilet facilities and oxygen and suction points on ward 17 was also not completed until after our inspection.

Managers identified nurse staffing as challenge during our inspection however with the exception of ward 14 this was not recorded as a risk on the divisional risk register.
On reviewing the surgical risk register we found as at the end of March 2018, four risks had reduced in score since it was last reviewed, three had increased and 28 had remained the same. However, not all risks were reviewed at the same time. Twenty one risks on the register were less than one year old but there were four which had been on the risk register for over two years. For example, there was a risk that was placed on the risk register since July 2015 around the lack of pain specialist nurses. Actions had been put in place to mitigate the risk but one of the actions had not been actioned until August 2017 and it was unclear if the other action had been actioned.

There was a further risk that had been added to the risk register in June 2016 with actions identified with a due date of September 2016. However, there was no record that these actions had been completed and an update was only recorded on the risk register in December 2017. This risk was in relation to delays in waiting for appropriate beds following surgery. Therefore, we were not assured that all risks were being managed in a timely way.

An integrated quality dashboard was used to monitor quality and performance across the trust. Data included incidents and complaints as well as mandatory training compliance, referral to treatment times, cancelled elective admissions and Friends and Family Test results. Minutes of divisional clinical governance meetings and divisional management meetings indicated some areas of performance were discussed such as incidents and complaints however we did not see evidence of discussion or scrutiny of overall divisional performance.

**Information Management**

The trust collected and analysed information to support its activities. We reviewed the integrated quality dashboard data relating to surgery, this included current performance with regard to national clinical audits such as the hip fracture audit and the oesophago-gastric cancer audit as well as the outcome of 52 week Breach Harm Reviews. A Breach Harm Review is an assessment of any harm suffered by a patient as a result of delay in receiving treatment.

**Engagement**

Plans were in place for the pre-operative assessment service to become drop in only rather than a mix of drop in and appointment as seen during our inspection. On enquiry managers told us there had been no patient engagement regarding the planned change to the delivery of the service.

Managers we spoke with told us that the patient and family experience group had been disbanded as part of a governance review however patient and family experience was reviewed at the divisional quality group.

Staff received a weekly email which contained updates on relevant trust information. The trust held Listening into Action groups to engage staff on issues that mattered to them and annual PROUD awards were held to recognise staff and celebrate achievements throughout the year.

Staff told us a debrief would be held in theatres following a traumatic incident or death to enable staff to discuss their experience.
Learning, continuous improvement and innovation

Lessons learnt were shared with staff electronically in weekly newsletters and in safety huddles.

Mortality and morbidity reviews were held following a patient’s death to examine practice and identify areas of improvement. Findings were presented to staff during monthly surgical audit days.

Equipment in use at the bedside enabled patient observations to be recorded directly into the electronic patient record. This meant that observations and Modified Early Warning Scores (MEWS) that detect changes in a patient’s condition were immediately available to any clinician accessing the electronic patient record.

The Wirral Acute Femoral Fracture Unit (WAFFU) had opened to facilitate timely treatment of patients with an acute fractured neck of femur however was not performing as planned at the time of our inspection until the resumption of elective orthopaedic surgery.

Monthly audit afternoons were held in theatres. These had incorporated three multi-disciplinary clinical simulation sessions within the last year. Following one of the clinical simulation sessions improvements were implemented with regard to storage and accessibility of emergency equipment to improve patient safety.
Wirral University Teaching Hospital NHS Foundation Trust

Evidence appendix

Arrowe Park Hospital
Arrowe
Wirral
CH49 5PE

Tel: 0151 678 5111
www.wuth.nhs.uk

Date of inspection visit:
13 to 15 March, 20 to 23 March to 1 to 3 May 2018

Date of publication:
xxxx> 2018

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.

Critical care

Facts and data about this service

The critical care unit at Arrowe Park Hospital is a 18 bedded unit commissioned to provide care and treatment for eight level three and ten level two adult patients. This configuration can be changed according to demand and the unit was equipped to be able to take 18 level three patients if required.

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

According to the Intensive Care National Audit and Research Centre data from 1 April 2017 to 31 December 2017, the units had 617 admissions. The service is a member of the Cheshire and Merseyside Critical Care Network. For the purposes of governance, critical care sits in the trust’s medical and acute division.

As part of the inspection we visited the unit on 13, 14 and 15 March 2018. We spoke with consultants, junior medical staff, a pharmacist, two pharmacist technicians, 27 members of the nursing team, one allied health professional, two members of support staff, one member of the housekeeping team, five patients and the families of eight patients. We also reviewed patient records, policies, guidance and audit documentation.
The trust has 24 critical care beds. A breakdown of these beds by type is below:

**Breakdown of critical care beds by type, Wirral University Teaching Hospital NHS Foundation Trust and England**

<table>
<thead>
<tr>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal, 25.0%</td>
<td>Neonatal, 23.9%</td>
</tr>
<tr>
<td>Adult, 75.0%</td>
<td>Adult, 68.4%</td>
</tr>
</tbody>
</table>

(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**

**Mandatory training completion rates**

Staff attended mandatory training courses but compliance rates were below the trust target. Staff accessed mandatory training online and face to face. We viewed electronic staff records which recorded mandatory training compliance for staff by each module.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

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

A breakdown of compliance for mandatory courses from April to October 2017 for nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td>54</td>
<td>101</td>
<td>53.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block B</td>
<td>45</td>
<td>101</td>
<td>44.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block A</td>
<td>25</td>
<td>101</td>
<td>24.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security 1</td>
<td>2</td>
<td>101</td>
<td>2.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management Level 2</td>
<td>0</td>
<td>15</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Block A contains: manual handling, health and safety level one, risk management level one, consent awareness, end of life care and moving and handling modules. Block B contains: fire safety, infection prevention and control and medicines management modules.

The overall completion rate for mandatory training modules by nursing staff in critical care was 30.1%. Nursing staff did not meet the trust target for any of the five mandatory training modules.

A breakdown of compliance for mandatory courses from April to October 2017 for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td>6</td>
<td>14</td>
<td>42.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety Level 2</td>
<td>4</td>
<td>12</td>
<td>33.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block B</td>
<td>4</td>
<td>14</td>
<td>28.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block A</td>
<td>2</td>
<td>14</td>
<td>14.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management Level 2</td>
<td>1</td>
<td>12</td>
<td>8.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security 1</td>
<td>1</td>
<td>14</td>
<td>7.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Block A contains: manual handling, health and safety level one, risk management level one, consent awareness, end of life care and moving and handling modules. Block B contains: fire safety, infection prevention and control and medicines management modules. The overall completion rate for mandatory training modules by medical staff in critical care was 22.5%. Medical staff did not meet the trust target for any of the six mandatory training modules.

(Source: Routine Provider Information Request (RPIR) P40 –Mandatory and Statutory Training)

Safeguarding

Safeguarding training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust reported that their protecting vulnerable people courses contain safeguarding adults and children modules. Data on the individual modules within these courses was not provided.

The trust set a target of 95% for completion of protecting vulnerable people training.

The breakdown of protecting vulnerable people training completion for nursing staff in critical care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>56</td>
<td>100</td>
<td>56.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 3</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Please note that the trust informed us that their PVP courses contain modules relating to Safeguarding Adults, Safeguarding Children, PREVENT, Mental Capacity Act, Deprivation of Liberty Standards, Domestic Violence, MHA and Dementia Awareness.
PVP level 2 training had been completed by 56 of the 100 nursing staff eligible for it (56.0%) in critical care. However, the trust indicated that the one member of nursing staff eligible for the level 3 course had not completed the training while no staff were eligible for the level 1 module.

The breakdown of training completion for medical staff in critical care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>10</td>
<td>14</td>
<td>71.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust informed us that their protecting vulnerable people courses contain modules relating to safeguarding adults, safeguarding children, PREVENT, Mental Capacity Act, Deprivation of Liberty Standards, domestic violence, Mental Health Act and Dementia Awareness.

Protecting vulnerable people level 2 training had been completed by 10 of the 14 medical staff eligible for it (71.4%) in critical care. The trust indicated that no medical staff were eligible for level 1 or 3 training.

(Source: Routine Provider Information Request (RPIR) P40 – Mandatory and Statutory Training)

Cleanliness, infection control and hygiene

Not all clinical areas were found to be clean. We found, waiting rooms and corridors where the public had access to, appeared unkempt, were cluttered and on occasions dirty. Cleaning was highlighted in the February infection control meeting as an issue and it stated that clarification was needed on what responsibilities belong to the nursing teams and what should be carried out by the domestic teams. The outcome was to arrange a further meeting to discuss the issues and to develop a checklist for both groups of staff in order to ensure all tasks are completed in a timely and efficient way to the high standard that would be expected of a hospital.

We found equipment at patients’ bedsides to be clean and in a good state of repair.

On entry to the unit there were bottles of hand gels, however at one entrance to the ICU they were difficult to see and there was no sign to encourage visitors to use the gel. The other entrance displayed a large free standing sign, encourage the use of the hand gel.

There were no signs on entry to the unit for visitors to wash their hands.

We observed staff appropriately washing their hands, using hand gels and wearing personal protective equipment when delivering personal care to patients. We also spoke with patients and relatives who had observed this practice.

However, on four occasions we did observe nursing staff failing to carry out aseptic non touch technique (ANTT) when administering medication. The aseptic technique should involve the nursing staff using a clean trolley and tray to make up and subsequently dispense the medication from, washing their hands using the seven steps and use of gloves and aprons. We did not see the use of a separate trolley, we only saw one nurse washing her hands prior to donning her gloves. Gloves were worn in all cases, but no trays or clean and dedicated area for placing the key parts used for the administration, to ensure they remained clean. We spoke with the infection control nurse who told us that ANTT was initially assessed, but there was no time scale in place for updates therefore it was not clear as to how this was managed within the critical care area and whether this was assessed regularly.
The ICU and HDU areas both had two designated side rooms. However, neither of these rooms were equipped with negative pressure flows, this meant that there was no directional airflow in order to isolate the patient from the rest of the unit, therefore they could not support patients with specific infection prevention requirements which required air flow.

During our visit we observed a bag of patient’s clothes on the floor in ICU, not stored away appropriately and a vacuum-assisted closure was found on the floor. (A vacuum-assisted closure is used to remove blood or serous fluid from a wound or operation site).

We found that high dusting in ICU had not been carried out and the central nurse’s station was situated around structural pillars that were covered with paper notices and ‘thank you’ cards, some dating back to 2015.

Two ceiling panels, above one of the bed spaces in ICU, were very mouldy and needed replacing. We looked at seven sharps bins and two of them did not have a date of when they were opened and a bin in the sluice did not have a complete closing/sliding lid.

During our inspection we found a small open bucket of cleaning fluid, on the ICU nurses station. The bucket was unattended, did not appear to be in use and had no identifying label. We raised the incident with management and the bucket was removed.

Environment and equipment

The critical care unit was initial designed to be the HDU, therefore the building did not comply with the Department of Health’s building guidance (Health Building Note 04-02: Critical care units), which is best practice guidance on the design and planning of new or reconfigured healthcare buildings. This had been reported and was featured on the unit’s risk register, which stated that there was a risk to patients in the critical care unit from hospital acquired infections due to lack of adequate isolation facilities and lack of the recommended space for each bed area. The recorded risk was that the unit had five isolation rooms out of 18 bed spaces, and at times it was not possible to effectively isolate all patients with multi-resistant or virulent pathogens. A further risk on the register regarding the facilities in the unit, reported that the unit would not be compliant unless a rebuild /refurbishment was undertaken.

We saw only four single bed side rooms and, according to health building guidance, Health Building Note 04-02, single-bed rooms with lobbies are required for the isolation of patients to control the spread of infection or for the protection of immunosuppressed patients. The side rooms in both ICU and HDU were not equipped with lobbies.

The environment appeared to be a main concern; however, the facilities that were in existence were not maintained to the best possible standard. The overall appearance to the entrance to the unit was shabby and the walls were littered with paper signs, mostly out of date. We saw a notice board displaying ‘Thank you cards’ but on viewing them they were dated 2015.

The floors at both entrances to the unit had large stickers on them that had worn away and were peeling. They were both a trip hazard and an infection control risk as the floors could not be cleaned effectively.

We spoke with the follow-up nursing team who said there was not enough space within the unit and this meant that they did not have a clinic, or office, so they used the relatives’ room. This was impractical and did not provide any privacy for the staff or service users.

We found the two sluice areas in the unit were not secure and inside were cleaning products which were also not secured. Both these rooms were off corridors accessible to the public.
We reviewed the resuscitation equipment; including defibrillators and difficult airway management equipment and found they were all within the manufacturers’ expiry dates. All emergency equipment was checked daily, signed and dated.

There was a rolling replacement programme for all equipment in the unit, supported by the electro bio-medical engineer’s team. We were told that every 12 months the team review each piece of equipment and replace any old equipment. In the previous year 11 ventilators were replaced as a result of them being over 10 years old. The team ensure that the unit had sufficient equipment to meet patient’s needs; this reflected what we saw on the unit. The unit was informed by email when a piece of equipment was near to review. However, on reviewing the ITU inventory schedule it was found to be out of date. It was acknowledged that it was out of date and that it would require updating.

We were told by staff on the unit that the process of replacing/fixing equipment was time consuming. Recently a scanner had become defective and was reported. The electro bio-medical engineers team told us that they first attempt to repair the equipment and if they cannot they condemn the equipment and obtain three quotes for replacements. They are then sent to the unit for discussion and the clinicians must then choose the replacement.

The electro bio-medical engineer’s team also carried out electrical safety testing of all equipment on the unit and ensured any maintenance work was carried out. Any service sheets were attached electronically.

A health care assistant also acted as a technician for the unit, liaising with the electro bio-medical engineer’s team when necessary. This ensured that all equipment was checked and cleaned.

The ICU had one mixed toilet with shower; the floor needed replacing and looked dirty. There was no label on the shower curtain to indicate when it needed cleaning/replacing and the shower drain was dirty. The ceiling was made up of large, polystyrene tiles and one had been removed to reveal wires and a vacant space.

We found oxygen cylinders lined up in the corridor leading to HDU and on the floor in some bed spaces. Gas cylinders should be stored in either a storeroom that is part of the building or a separate, specially constructed building, both areas being used exclusively for medical gas cylinders. They should be kept dry and in a clean condition. Existing storage facilities should have been designed to comply with the recommendations of the Department of Health’s Health Technical Memorandum 16. The Trusts own gas cylinder policy stated; ‘The security of the store must be maintained at all times. Medical gas cylinders are known to be a desirable by thieves.’

The double entrance doors to the ICU opened directly into a patient bed area which may affect that patient’s privacy and dignity, additional doors had been constructed from the corridor to create an atrium, however, they were not yet secure as no intercom had been fitted.

There was no reception desk within ICU/HDU and calls were answered by staff at the nursing station. Staff also had to stop nursing in order to greet visitors entering the unit.

We saw three sets of filing cabinets at the entrance to ICU, with a large shelf above displaying files including; palliative care, renal, IC audit files, ventilator CB. This area looked cluttered and gave the feeling that you were entering an office rather than an ITU. In addition to the appearance, it would be difficult to clean this area effectively.

Staff rooms were small and untidy and we were informed that in 2017 they had had a problem with mice.
Assessing and responding to patient risk

The risks to patients were assessed and their safety monitored and managed so they were supported to stay safe.

The unit had an outreach team which is a multidisciplinary team comprising of senior doctors, senior nurses and anaesthetic staff, all with a background in intensive care. The outreach team consisted of three whole time equivalent band six nurses and one member of staff from ICU who worked a seven day week and were available from 8am to 8pm.

From 8pm to 8am and during weekends and bank holidays cover was by the clinical coordinators.

The outreach team also responded to cardiac arrests within the hospital.

The outreach team were responsible for responding to patient’s who required psychological support

All patients admitted acutely to the unit were continually assessed and staff used the national early warning system which included chronic obstructive pulmonary disorder adjustments, to identify patients who may be at risk of deterioration. The national early warning systems are widely used in hospitals to track patient deterioration and to trigger escalations in clinical monitoring and response. If a patient’s national early warning system score was of concern then they were immediately referred to both a doctor and a member of the critical care outreach team. The outreach team would also support patients discharged from critical care areas to the wards.

The unit used the Richmond Agitation-Sedation Scale to detect delirium. Richmond Agitation-Sedation Scale is a medical scale used to measure the agitation or sedation level of a patient. Obtaining a Richmond Agitation-Sedation Scale score was the first step in administering the Confusion Assessment Method in the ICU (CAM-ICU), a tool to detect delirium in intensive care unit patients.

We saw evidence that the unit used a sepsis care bundle for the management of patients with resumed/confirmed sepsis.

We discussed the high sepsis rate with management and they believed that there had been a coding issue. There had been a recent change to ICU codes.

Nurse staffing

There was adequate staffing to meet patient needs. The unit was meeting the minimum recommendation of level three patients requiring a registered nurse/patient ratio of a minimum 1:1 and level two patients a minimum 1:2 to deliver direct care.

The trust reported the following nurse staffing numbers for critical care at Arrowe Park Hospital in March and October 2017. The service had established rates of over 90% in both time periods.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Actual WTE Staff in post</th>
<th>Planned WTE staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>88.0</td>
<td>97.3</td>
</tr>
<tr>
<td>October 2017</td>
<td>92.5</td>
<td>97.3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The unit had a dedicated pharmacist, however, it was reported on the risk register that there was a risk to patient safety and experience as the pharmacy support on unit was below the standards set out by the Cheshire and Mersey Critical care network. The Cheshire and Mersey critical care
network state that pharmacy provision for adult critical care should be 0.1 whole time equivalent per level 3 bed and 0.05 per level 2 bed. This meant that for this unit there should be 1.3 whole time equivalent pharmacy cover. There was currently one whole time equivalent.

The following nurse staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

**Vacancy rates**

From November 2016 to October 2017, Arrowe Park Hospital reported a vacancy rate for nursing staff in critical care of 9.5%. The trust does not have a target vacancy rate.

At the time of our inspection the unit had eight whole time equivalent vacancies for band five registered general nurses; two had been filled and were due to start.

(*Source: Routine Provider Information Request (RPIR) P17 Vacancies*)

**Turnover rates**

From November 2016 to October 2017, Arrowe Park Hospital reported a turnover rate of 5.3% for nursing staff in critical care. This met the trust target of the turnover rate being less than 10%.

(*Source: Routine Provider Information Request (RPIR) P18 Turnover*)

**Sickness rates**

From November 2016 to October 2017, Arrowe Park Hospital reported a sickness rate for nursing staff in critical care of 6.8% which was higher than the trust target of 4%.

(*Source: Routine Provider Information Request (RPIR) P19 Sickness*)

**Bank and agency staff usage**

The unit was using bank and agency staff, however the unit did not use greater than 20% of registered nurses from bank/agency staff on any one shift.

From November 2016 to October 2017, the trust reported 77 shifts filled by bank staff (0.3%) and 333 shifts filled by agency staff (1.4%) in critical care at Arrowe Park Hospital. There were 346 shifts not filled by bank or agency staff (1.5%).

Agency or bank staff that were used carried out an induction to the unit.

A breakdown of bank and agency usage by staff type is shown below:

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>65 (2.7%)</td>
<td>12 (0.1%)</td>
<td>77 (0.3%)</td>
</tr>
<tr>
<td>Agency</td>
<td>0 (0.0%)</td>
<td>333 (1.6%)</td>
<td>333 (1.4%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>51 (2.1%)</td>
<td>295 (1.4%)</td>
<td>346 (1.5%)</td>
</tr>
</tbody>
</table>

(*Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency*)
Medical staffing

The trust reported the following medical staffing numbers for critical care at Arrowe Park Hospital in March and October 2017. The service was over-established in both time periods.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Actual WTE Staff in post</th>
<th>Planned WTE staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>12.0</td>
<td>11.7</td>
</tr>
<tr>
<td>October 2017</td>
<td>14.0</td>
<td>11.7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

We found appropriate medical cover at all times. The patient ratio to a consultant was 1:15 when on call and during the day time 1:7.5 patients.

At the time of our inspection there were 12 consultants employed in HDU and ICU and all were associate fellow of Faculty of Intensive Care Medicine.

The consultants work patterns delivered continuity of care; working 8am to 6pm and 5pm to 8am on call, seven days a week. We were told that handover was at 5pm, however the majority of the on call night staff stayed in the unit until approximately 10pm and then were contactable by telephone. All ICU/HDU consultants lived within 20 minute drive from the hospital.

Consultants participating in the duty rota were not responsive for delivering other services anywhere else in the hospital. The consultants would attend to patients who were critical care patients in theatre recovery; however, we were informed that this rarely occurred.

All the consultants were trained in advanced airway techniques.

The following medical staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Vacancy rates

From November 2016 to October 2017, Arrowe Park Hospital reported a vacancy rate for medical staff in critical care of -1.8%, indicating that the service was over-established. The trust does not have a target vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From November 2016 to October 2017, Arrowe Park Hospital reported no turnover for medical staff in critical care. The trust has a target of turnover being less than 10%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From November 2016 to October 2017, Arrowe Park Hospital reported a sickness rate of 0.1% for medical staff in critical care which was lower than the target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and locum staff usage

From November 2016 to October 2017, the trust reported that nine shifts (0.2%) in critical care were filled by bank staff and that there was no locum or unfilled shifts. The bank shifts were for doctors in training.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. The unit had moved over to electronic patient records about two years ago. Some staff told us they still had problems in using the system and expressed that they were more comfortable with the paper records. The common complaint was that they had to open several screens to update the patient records and their daily checks were not displayed on one page.

The system was a hospital wide system with a specific critical care module. It was comprehensive and easily assessable. The system included electronic prescribing and was also adapted specifically for critical care. In the near future the system would also allow staff to access GP and social services patient records.

We looked at five electronic patient records within ICU and HDU; we noted that on one patient’s records in ICU, a Richmond Agitation-Sedation Scale score had been carried out, but not a Confusion Assessment Method score and only three of the patients had had their nutrition checked.

The Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form was to be replaced next year, therefore DNACPR forms were not available electronically, so paper forms in the medical notes were being used. We viewed two of these forms for patients in critical care, which were fully completed and signed. DNACPR forms will be replaced with Recommended Summary Plan for Emergency Care and Treatment (ReSPECT). ReSPECT is a process that creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment.

We reviewed five patient’s prescription cards, as these were recorded electronically there was no difficulty in reading them. We found all the prescriptions were signed and dated accordingly and drugs were documented as required.

The records that we looked at had allergy documentation, Venous thromboembolism (VTE) checks and prescriptions in place and medicines reconciliation completed. There was good evidence of antimicrobial stewardship. The electronic record did not allow a review date for prescriptions to be entered, but the pharmacy team communicated this via intervention notes. The electronic record had a new functionality antimicrobial stewardship which supported the appropriate prescribing with indication and laboratory results.

Medicines

The service prescribed, gave and recorded patient’s medicines well, however they did not always follow guidance when storing medicines.
Patients received the right medication at the right dose at the right time. We looked at five electronic patient records which all showed any patient allergies had been clearly documented.

The Trust had an up to date medicines management policy which was available to all staff on the intranet.

We observed that medications were stored correctly in locked cabinets and staff told us that the keys for the medication cupboards were held by the recovery nurse.

We reviewed the medication storage treatment room. The room was a secure key coded room, which the staff had access to. The room had cupboards and fridges for the storage of mediation. One of the fridges was very full, over-packed refrigerators, lead to poor air flow and potential freezing of stock (especially near the fridge walls), there SHOULD be sufficient space between the fridge items to allow the air to circulate.

There were four out of date flucloxacillin bags that needed to be removed. We identified out of date products in the treatment room cupboard; eight, 150 packs of lubricating jelly (Optilube) this expired 3 in March 2017, four in August 2017 and one in September 2017. We raised this with the management immediately.

A smaller fridge containing drugs was found to be secure. We found that there was regular monitoring of the room and fridge temperatures; however the fridge had several maximum readings above 8°C noted. Refrigerators to store medicines should maintain an air temperature of 2 to 8°C with the minimum of intervention. In March there were five readings across two fridges with a maximum of 10.4°C and in February there were 30 readings across two fridges with a maximum of 17.4°C. In February 2018 readings below 0°C were also noted with -2.2°C being recorded for eight days. Parameters for the fridge temperature were not displayed, therefore staff did not know if the fridge temperature recording was higher or lower than expected.

We saw that the control drugs cupboard was locked and a control drug record book was kept on the side. We observed the controlled drugs being signed into the ward controlled drugs register. The register was fully completed and the balances were correct.

We checked a sample of medicines from the secure cabinet, the fridge and other drugs cabinets, within the anaesthetics room and found them all to be within the manufacturers’ expiry dates and stored correctly.

We found the windows to the medicine store were open during our inspection. The windows were large and opened wide enough to allow a person to enter through. The windows opened onto a walkway shared with an occupied, open plan office. We immediately reported the incident and the windows were closed and secured. We were told that the windows had been opened due to the room temperature. The wall thermometer recorded the temperature as 24.5 degrees. We spoke with staff on the unit, who stated that the room temperature had always been a problem and it was always warm in the room. The staff were unsure if it had been reported. This posed a risk of medications, which are affected by higher temperatures losing their effectiveness.

**Incidents**

**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 January to December 2017, there were no incidents classified as never events for critical care at the trust.

(Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, there was one serious incident (SIs) in critical care at the trust which met the reporting criteria set by NHS England from January to December 2017. This was classified as a diagnostic incident including delay (including failure to act on test results and occurred in December 2017.

(Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017))

We viewed six serious incidents recorded since 11 July 2016; one of these was not directly linked to ICU. We saw informative recording of the incidents with each incident being allocated a number, the date was recorded, department, cause of the incident, summary of action taken and each incident was given a score dependant on its severity.

All incidents were discussed with staff at relevant meetings including: multidisciplinary meetings, senior staff meetings, network meetings, infection control, pressure ulcer, clinical governance and the safety summit. Nursing staff were informed daily of any incidents within the department at the morning huddle, this was fed back to them from the matron. Incidents were also discussed in the band 4 and band 5 nurse meetings.

Staff in the unit were aware of how to report an incident and were encouraged to do so. Learning was shared from the findings. Staff used an electronic reporting system which was sent automatically to management. In the past reporting had been low and managers felt this was down to staff believing reporting incidents was linked to ‘blaming’ staff. We were told that work and re-training had been carried out to educate staff on incident reporting. They had since seen an increase in reporting.

We saw evidence of a monthly mortality review service group meeting which was held at the hospital, we reviewed three sets of minutes from the meetings. In December 2017 the meeting moved to an electronic process as not enough consultants could attend.

Staff had varying levels of understanding of the duty of candour (meaning they should act in an open and transparent way in relation to care and treatment provided). It was clear that senior level staff understood and a number of examples where duty of candour had been implemented within the unit were shared. However, nursing staff struggled to explain the process and its importance. We saw evidence of the duty of candour being applied when a patient was given the wrong dose of insulin, the patient and family were alerted immediately of the mistake and an apology given.

**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 no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from December 2016 to December 2017.  
(Source: NHS Digital)

At the time of our visit we saw patient safety thermometer data for previous three months; from December to February 2018 HDU had 100% harm free care. However, ICU was 75% in December 2018. We were informed there had been one new pressure ulcer, two catheter infections and a urinary tract infection on the unit. January 2017 saw 100% and in February 2017 the results fell again to 89%.

Is the service effective?

Evidence-based care and treatment

The unit was informed of any changes to relevant National Institute for Health and Care Excellence guidance from the trust via weekly updates through a trust wide email. The managers of the unit made staff aware of the changes at the morning huddles.

The unit took part in local and national audits, including the Intensive Care National Audit and Research Centre. This meant that care delivered and outcomes for patients were benchmarked against similar units nationally.

There was a wide range of local policies, procedures and standard operating protocols in place which were easily accessible via the trust wide intranet. We looked at a sample of policies including the discharge policy and policy on medical gas cylinders, the provision and use, which were up to date. However, the corporate and local induction policy was due to be renewed on 5 December 2017.

The consultant critical care pharmacist had been involved in the preparation of guidelines and policies including the policies for analgesia and sedation and symptom control in end of life care on critical care.

The unit carried out sepsis screening which was managed in line with National guidance. There was an increase in sepsis rates. An audit was carried out from data collected in January 2016, as a result of which a number of actions were put in place to reduce the numbers. The actions included; Sepsis September’ education awareness events, new ‘Adult sepsis screening and action tool and sepsis six pathway’ launched in October 2017 and the trust employed a matron, who now has responsibility for the wider care of “Deteriorating Patients”, but with a major focus on Sepsis and Critical Care Outreach.

The sepsis screening was part of the care bundles and had recently been updated with the ‘sepsis six’. The sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. The sepsis six consists of three diagnostic and three therapeutic steps, all to be delivered within one hour of the initial diagnosis of sepsis.

The unit had a matron who was also the research nurse and carried out service improvement audits and quality standards audits. The care bundle audits had recently been amalgamated into one audit which was easier to manage. Ten patient’s notes were looked at over a period of one month and any failing areas were; discussed at the staff huddles, shared by email, shared on the
closed nurse social media page and the nurse educator was informed. A recent audit showed that Confusion Assessment Method (CAM) score for use with ICU patients had not been completed on patients records. This resulted in the multidiscipline team working to ensure new staff completed the record and were aware of how to find it on the system.

There was currently no support within the unit for patients who were suspected to be experiencing depression or require psychology or psychiatric support. A referral was made via their GP.

**Nutrition and hydration**

During our visit we observed that nutritional and hydration needs of patients were being met. Staff and patients had access to specialist nutritional advice from the dietician team. There was a designated dietician assigned to the unit, support was 1.5 Whole time equivalent for critical care. The dietician would check the referrals to the unit and attend when required. However, they were only available Monday, Tuesday and Friday’s.

The malnutrition universal screening tool was used by the staff in the unit to identify and monitor the patients’ nutritional needs. The malnutrition universal screening tool has been designed to help identify adults who are underweight and at risk of malnutrition, as well as those who are obese. The malnutrition universal screening tool was not used on a patient if the patient was under the dietician. We were informed by the dietician that staff were very interested in nutrition and were very closely involved.

We looked at five electronic patient records and saw evidence that each patient had had their fluid state/fluid balance checked.

**Pain relief**

The unit had a dedicated pain team available to support patients.

All patients with patient controlled analgesia; epidural and rectus sheath catheters were referred from theatre to the unit and were reviewed by acute pain team. The team consisted of one nurse specialist and two consultants. When the pain nurse was on annual leave cover was provided for the unit by the maternity anaesthetist.

The pain team were trying out a new pain tool for ventilated patients, which could also be used for dementia patients.

We looked at five electronic patient records and found that one patient out of five we looked at had not had a pain assessment carried out. We did however see that pain was discussed at ward rounds.

The Trust participated in the Friends and Family Test (FFT) which is an important feedback tool that supports the fundamental principle that people who use NHS services, should have the opportunity to provide feedback on their experience. We did not have a break down for ICU and HDU; however results for January 2018 showed 98% of patients would recommend the hospital as an inpatient. WUTH continued to achieve the highest performance for recommend and not recommend rate in comparison to the national average, regional averages and local peers during January 2018. However response rates were below both national and regional averages and require improvement.
Patient outcomes

ICNARC Participation

The trust has one 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. We used data from the 2016/17 Annual Report. More recent quarterly data may be available online. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (all patients)

For the unit, the risk adjusted hospital mortality ratio in 2016/17 was worse than expected. The unit was aware of this and we spoke to the critical care lead who informed us that the rise had been around emergency surgical patients. An action plan had been implemented and the unit was involved more directly with decision making in regards to this category of patient. The figures had feel slight over the last quarter.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (for low risk patients)

For the unit, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was as expected.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The unit had a dedicated ICNARC clerk who collated all relevant information and submitted the evidence to ICNARC every quarter. As each patient is discharged from ICU the data was collated.

The unit had a higher than average infection rate for unit acquired infections. Unit-acquired infection is defined as the presence of an infection in any blood sample taken for microbiological culture after 48 hours following admission to the unit. The ICNARC data from the 2016/17 Annual Report showed; Unit acquired meticillin-resistant Staphylococcus aureus (MRSA) - Arlower Park 0.5%, other units 0.2%, Unit acquired C-Diff (Clostridium difficile, a bacterium that can infect the bowel and cause diarrhoea) – Arlower Park 0.6%, other units 0.2%, Unit acquired VRE – Arlower Park 1.3%, other units 0.2%.

(VRE is defined as the presence of VRE (vancomycin resistant enterococcus) in any sample taken for microbiological examination after 48 hours following admission to the unit and while still in the unit.)

From the ICNARC data a deceased report was also compiled for the mortality and morbidity meetings.

We saw that the unit acted on the data and an example of this was a rise in standardised mortality ratio in emergency surgery patients. Standardised mortality ratio is a ratio between the observed number of deaths in a study population and the number of deaths would be expected, based on the age and sex specific rates in a standard population and the age and sex distribution of the study population. As a result of this they created an action plan and the rates had fallen over the last three months.
Competent staff

In the unit 53% of nursing staff held a post registration award in critical care nursing. According to the national core standard for critical care units the minimum of 50% of registered nursing staff should be in possession of a post registration award in critical care nursing, therefore the unit were above the required level. The practice educator told us they would like more staff to hold this award to compensate for staff leaving.

It was also essential for the mentors to hold a post registration award in critical care nursing, as the student nurses needed to be signed off after their last placement by the mentors. Figures showed that the unit was oversubscribed with staff holding the post registration award and therefore the unit was finding it difficult to gain further places for nurses, however there were not enough nurses with the award to mentor the students.

Trainee doctors on the unit all had a mentor.

The unit had two designated, full time clinical practice nurse educators in post that supported staff with courses and equipment training.

All nursing staff appointed to critical care were allocated a six week supernumerary period, allowing them time to develop basic skills and competencies to safely care for critically ill patients.

New starters were reviewed by the practice educators to ensure that they were up to date with; electrical safety, manual handling, infection control, mental capacity act and safeguarding level two.

Current band 5 nursing staff on the unit did not complete the immediate life support (ILS) course; we were told this was down to funding. It was planned for this year to train band 6 nurses in immediate life support.

The advanced life support training had been completed by four ICU nurses, two members of the outreach team and the clinical co-ordinator.

All consultants on the unit were trained in advanced airway techniques.

At the time of our visit the practice educators had been informed that they would now be responsible for training staff on the unit with the electronic patient record system. Up until now the Trust IT team had been responsible for the training. We spoke with one practice educator who was prepared to take on this role however did not feel that they were the most appropriate choice for IT training.

Appraisal rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From April to October 2017, 33.6% of staff within critical care had received an appraisal compared to the trust’s target of 88%.

The outreach team conduct education around patient deterioration, which involves the nursing staff first attending an acute illness management course.

A split by staff group can be seen in the table below:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals completed</th>
<th>Eligible staff</th>
<th>Appraisal rate</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>5</td>
<td>14</td>
<td>35.7%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>35</td>
<td>101</td>
<td>34.7%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>3</td>
<td>13</td>
<td>23.1%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working

A multidisciplinary meeting took place monthly, where risks in the unit were discussed. Consultant led ward rounds took place daily, which included a consultant and a pharmacist. We witnessed a ward round during our visit and those present were; a consultant, the nurse in charge, four trainees and a pharmacist. The pharmacist was an integral part of the multidisciplinary team and we saw examples of discussion with the team to ensure both appropriate prescribing and timely supply of doses coordinated.

The microbiologist attended a separate ward round in the afternoons and the physiotherapist attended the unit daily, but they did not take part in the morning ward round.

A patient could be referred to the palliative care team via the electronic system.

A learning disabilities nurse was available one day a week to support the whole trust and the unit could make a referral to them if required.

The trust had a dementia nurse, who was also the falls nurse, but there were no link nurses on the unit.

The unit had access to an organ donor nurse, their contact details were retained in a file and on the unit information board. Work was in progress to create an organ donor like nurse for the unit.

There was a robust and comprehensive handover procedure for teams within the unit for when patients were discharged to the ward.

We observed the handover from night staff to morning staff, which was led by the ward sister; staffing levels were discussed, bed vacancies and details of each patient in the unit.

The outreach team reviewed all patients on wards who had been discharged from critical care.

The physiotherapists were available seven days a week and on occasions there were two physiotherapists available for ICU/HDU at weekend.

There was only one physiotherapist available on the unit during the week. This fell short as the national guidelines for the provision of intensive care services, recommend a ratio would be one whole time equivalent physiotherapist to 4 ICU Level 3 beds.

We were informed that the physiotherapist mainly saw to patient’s chest complications and there was no rehabilitation on the unit. Two weeks prior to our inspection a rehabilitation service had started Monday to Thursdays for ICU/HDU patients. However, this meant patients did not receive rehabilitation for three days of the week. In accordance with the national core standard for critical care units, 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, at a level that enables the patient to meet their rehabilitation goals.
Seven-day services

A consultant was available on the unit from 8am to 6pm shift and on call from 5pm to 8am. While on call consultants were contactable by landline and mobile phone they all lived within a 30 minute travel time from the trust.

All patients on the unit were reviewed daily by the consultant on a formal ward round. The consultant would then see the patient again in the morning, on the microbiologist ward round and in the evening on a consultant to consultant ward round.

Critical care had a seven day pharmacy service; staff were mentored and trained by the consultant pharmacist to be able to provide the role.

Health promotion

Transfers of sick patients from the unit were supported by the outreach team in line with the trust’s policy.

At the time of our visit the dietician attended the unit as required only on Mondays, Tuesdays and Fridays. There had been a dietician assigned to ICU, however the dietician had recently left and it was unsure as to whether their position was to be filled.

We spoke with the matron for deteriorating patients who told us that they were working closely with community and North West ambulance service to support them

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust informed us that their protecting vulnerable people courses contain modules relating to safeguarding adults, safeguarding children, PREVENT, Mental Capacity Act, Deprivation of Liberty Standards, domestic violence, Mental Health Act and Dementia Awareness.

The trust reported that their Protecting Vulnerable People (PVP) courses contain modules relating to the Mental Capacity Act (MCA), Deprivation of Liberty safeguards (DoLS) and Mental Health Act training. Data on the individual modules within these courses was not provided.

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

From April to October 2017, PVP training had been completed by 58.6% of all staff in within critical care.

The breakdown of PVP training completion for nursing staff in critical care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>56</td>
<td>100</td>
<td>56.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 3</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Please note that the trust informed us that their PVP courses contain modules relating to Safeguarding Adults, Safeguarding Children, PREVENT, Mental Capacity Act, Deprivation of Liberty Standards, Domestic Violence, MHA and Dementia Awareness.

PVP level 2 training had been completed by 56 of the 100 nursing staff eligible for it (56.0%). However, the trust indicated that the one eligible nursing staff had not completed level 3 course while no staff were eligible for the level 1 module.

The breakdown of training completion for medical staff in critical care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>10</td>
<td>14</td>
<td>71.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Please note that the trust informed us that their PVP courses contain modules relating to Safeguarding Adults, Safeguarding Children, PREVENT, Mental Capacity Act, Deprivation of Liberty Standards, Domestic Violence, MHA and Dementia Awareness.

PVP level 2 training had been completed by 10 of the 14 medical staff eligible for it (71.4%). The trust indicated that no medical staff were eligible for level 1 or 3 training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We looked at one electronic patient record who had been flagged by the safeguarding team. There had been a discussion about whether the patient had capacity and we saw evidence that a mental capacity assessment had been carried out and “this is me” worksheets had been completed. They were also conducting delirium tests daily.

Is the service caring?

Compassionate care

Staff cared for patients with compassion and treated patients with kindness, dignity and respect. Feedback from patients confirmed that staff treated them well and gave them emotional support.

We spoke with eight relatives who all told us that the staff in the unit were caring and respectful to them and the patients. Relatives we spoke to said that they felt their relative was care for well in the unit and were fully informed about what was happening to them.

We spoke with five patients who were all happy at their treatment and emotional support. One HDU patient told us that they felt very comfortable, the nursing staff attended to their every need and they were well looked after.

We spoke with a patient in HDU who was due to be discharged home. The patient had been advised about their medication by the pharmacist and the patient and their relative said ‘they couldn’t fault the care it had been fabulous’.

As the unit only had four private rooms across HDU and ICU patient’s privacy in general was difficult to maintain. The bed areas were separated by curtains which could be closed, however the density of the curtains did not reduce the level of general noise transmitted and did not improve the level of auditory privacy in the bed space.
Emotional support

We spoke with the follow up nurses and found that one nurse had been trained in counselling and offered bereavement support.

A church service was organised once a year for people who had lost loved ones on the unit.

The unit has recently introduced patient diaries for the unit. Intensive care patient diaries are a tool in helping patients come to terms with their critical illness experience. After critical care patients have been discharged they often report having gaps in their memory from their illness. The diary helps fill this memory gap and help patients to understand what has happened to them.

We found that the dairies were not given to the patient on discharge, but kept by the outreach team until they are reviewed with the patient on their return for a follow-up appointment. We noted a number of patient diaries that had not been collected; these belonged to patients who had chosen not to attend their ICU follow-up appointment. We were informed that these dairies would be sent out to patients, though they had not been at the time of our inspection.

Understanding and involvement of patients and those close to them

Staff communicated well with patients in a manner that they could understand their care, treatment and condition. We spoke with an elderly patient in HDU who was fully aware that she required an operation that afternoon, under general aesthetic. The patient was informed of the procedure and why they needed the operation, they said it had been explained well to them.

The unit had access to a donor nurse who the staff knew how to contact, who approached patients’ relatives about organ donations when treatment was being withdrawn. Whilst we were on inspection, a family were present when an organ donation had been made. The nursing staff were understanding and caring towards the relatives.

Patient information leaflets were sparse and those we saw available in the waiting rooms included; Macmillan information, blood and transplants, norovirus, protecting privacy and organ donor information. The leaflets were not displayed in an orderly manner. The leaflets were not readily available in different languages.

We saw one information leaflet for patients and relatives concerning MRSA, which was found behind a fire extinguisher and notice board at the entrance to ICU.

Is the service responsive?

Service delivery to meet the needs of local people

The facilities and premises were not appropriate for the services that were delivered. The HDU ward was once the ICU and is still sign posted as such. The ICU and HDU appear tired due to the age of the premises.

The critical care follow up team offered both physical and psychological support to patients and their families following critical illness. The clinic is run by trained ICU senior nurses, one of whom is a trained nurse counsellor. Critical care consultant advice is available. Bereavement support can be accessed by anyone; family or friend if needed.

There was no reception desk within ICU/HDU and calls were answered by staff at the nursing station. Staff had to stop nursing in order to greet visitors entering the unit, though we did speak to
relatives who had not had difficulties in contacting the unit, or being allowed entry. Three times a week volunteers came in to answer the telephones, which the staff found very beneficial.

There were two waiting rooms for relatives; one located at the entrance to the corridor leading to HDU and one at the entrance to ICU. The waiting room off the corridor was used by relatives going to HDU and ICU; it was clean, but tired. There were vending machines supplying refreshments, but very little else in the room. The ICU waiting room, was dark, uninviting, had no refreshment facilities and was also tired. Staff had attempted to brighten the room up with paintings on the walls. There was a mixed sex toilet attached to the waiting room which was out of order. The toilet had no seat; we were told this had been reported. The floor was dirty and tired. There were no reading materials or television available in the waiting rooms.

Meeting people’s individual needs

The unit used patient passports to aid communication. Patient passports are a simple and practical guide to help people communicate with someone who is non-verbal. It contains personal information about their needs, such as their medical condition, likes and dislikes.

For service users whose first language was not English, a telephone interpreting system was available and on site interpreters were easily accessible to the department.

The unit had purchased ten tablet computers through a charitable donation. The computers had wipe able protective covers for infection control and were given out to patients in HDU and ICU. The patients were able to play games and read on the tablets. We were told that the tablets had also come been a useful to aid to communication with a patient who could not speak English. The staff used a language application to translate conversations with the patient.

Access and flow

Bed occupancy

From December 2016 to November 2017, Wirral University Teaching Hospital NHS Foundation Trust’s adult bed occupancy was generally similar to the England average.

After peaking in March 2017, bed occupancy showed a trend of decline from March to October 2017, before rising again in the most recent month, November 2017.

Adult critical care bed occupancy rates, Wirral University Teaching Hospital NHS Foundation Trust

![chart]

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)
We looked at five patient records and all five patients had received a consultant’s review on admission to critical care.

Delayed discharges

For the unit, there were 6,570 available bed days in 2016/17. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was similar to the national average.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The trust were aware of the delayed discharges in ICU/HDU and the unit had raised this issue on the risk register. The risk was recorded as; patient dignity and comfort due to delayed discharge from the critical care unit to inpatient speciality wards. Single sex breaches were also acknowledged on the register; single sex accommodation breaches due to patients remaining in mixed sex accommodation and not requiring emergency treatment. Patients who are deemed fit for discharge from critical care should be transferred to an appropriate inpatient ward in a timely manner. Currently discharges from critical care that were delayed by more than 24 hours from the medical decision to discharge are reported as single sex accommodation breaches to the commissioners. Keeping medically fit patients on the critical care unit is an inappropriate use of resource and impacts negatively on patient dignity.

Action had been taken by the unit in an attempt to reduce the delayed discharges. Breaches were recorded as a clinical incidents and forms completed to raise awareness in the organisation. We saw single sex breaches had been recorded as incidents. The bed capacity meeting standard operating procedure was modified to include details of outstanding critical care discharges, and these were highlighted and escalated at the six, daily bed management meetings. However, it was noted that the breach was again down to the environment and it was recorded that the critical care unit did not have the facilities to deliver single sex accommodation to patients due to the lack of adequate side rooms and bathroom facilities. The outstanding actions on the risk register highlighted that the bed management standard operating procedure lacked clarity around priority of bed allocation from critical care.

We spoke with the divisional medical director who told us that improvements had been made to rectify the delayed discharges in the unit and it was now discussed at the daily bed management meetings and given high priority. The meetings had also increased from four to six. The meetings were led by divisional directors or associate directors of nursing and escalated to executives if required.

People with urgent mental health needs in ICU/HDU, were seen within one hour of referral by an appropriate mental health clinician and assessed in a timely manner. The liaison service was provided by a trust in the same network. The service was 24 hours, seven days a week, however the patients must have had their physical health assessed and dealt with prior to assessment, unless there was an urgent need. Referrals were passed electronically after the physical needs were addressed.
Non-clinical transfers

For the unit, there were 835 admissions, in 2016/17. Compared with other units, non-clinical transfers within this unit were within expected limits.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Non-delayed out of hours discharges to the ward

For the unit, the proportion of admissions that were non-delayed, out of hour’s discharges to the ward was within expected limits in 2016/17, based on 586 admissions. These are discharges which took place between 10:00pm and 6:59am.

(Source: Intensive Care National Audit Research Centre (ICNARC))

We spoke with the management team and were told that patients were very rarely nursed in recovery whilst awaiting a critical care bed. We were told that this had only happened on one occasion in the last 12 months.

Learning from complaints and concerns

We saw a ‘suggestion box’ in the relative’s waiting room at the entrance to ICU; however, there were no suggestion cards to complete.

We were unable to assess whether the unit dealt with and investigated complaints efficiently, as there had been no complaints reported to the unit at the time of our inspection, or any time over the last 12 months.

Summary of complaints

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From November 2016 to November 2017, there were no complaints about critical care.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

The unit had not always had consistent leadership to provide support to run a service providing high-quality sustainable care. The ward matron had been off sick for a period of time and we could see that since the matron had been absent many changes had reverted, or failed to continue. For example, local audits had not been undertaken and safety thermometer results were still displayed in the corridor for July – to September 2017. Hand hygiene data was also out of date. In addition, the staff infection control information board displayed ‘infection control theme of the week’ for 10 January 2018.

There was a designated clinical director for intensive care, who was approachable for all staff and led a team of experienced senior nurses.
The unit had a designated lead nurse who was formally recognisable with overall responsibility for the nursing elements of the service. At the time of our inspection this was a band 7 sister, due to the band 8 matron being off sick for the past six months.

All managers spoke highly of the matron, who had only been in post for approximately 12 months. Changes had been made to systems and processes, to improve patient safety and the efficiency of staff; however, nursing staff were uneasy about the changes as they were being asked to carry out task that they had not been asked to do before, such as carrying out audits.

There was a clinical coordinator in ICU who remained supernumerary.

**Vision and strategy**

Senior managers told us the unit strategy was to make critical care the heart of the trust, driving quality of medical training. However, we did not see a formal strategy and vision for the service. We asked the service for this information who informed us that this had been held back until the new clinical lead commenced. We spoke with staff and they were not aware of what the unit’s vision and strategy was.

The clinical lead/ divisional medical director told us that the unit was going to be managed by the diagnostics and clinical support division instead of the medical division.

The existing critical care unit footprint and bed layout were outdated and did not meet the latest guidance published by the Department of Health in 2013. Issues with the environment not being compliant with latest guidance were recorded on the risk register and managers told us they had escalated these to be addressed on a number of occasions, but no action had been taken. At the time of the inspection there were no plans about when the facilities would be upgraded and improved to comply with national guidance.

We were informed that the unit had been recently measured to see if it could facilitate new innovative isolation ‘pods’. The pods provide isolation areas within the unit, allowing for more patients with infectious diseases to be treated in a contained environment. The pod has a large air filtering system, which works on a negative pressure system to keep infections in, recycling the air, ensuring that the air is clean and therefore the likelihood of infection is reduced. However, we were not shown any reports and were told that the funding had not yet been granted.

**Culture**

Staff did not always feel supported, respected or valued by senior managers in the medical division due to the continual expectation for them to cover other areas of the hospital. All nurses we spoke with raised this issue. Staff saw being called to cover other areas of the hospital, as a negative and some expressed that they felt ‘out of their depth’ when moved to cover duties elsewhere. Management had told us that the unit had had relatively low periods of admissions and therefore it was necessary to move staff to other areas of the hospital to alleviate pressures.

One member of staff told us that the high number of staff leaving the unit (14 members of staff in 2017 and six so far in 2018) was due to the staff being uncomfortable with having to be moved from ICU to cover other areas. The staff had not received a formal exit interview, however they had been asked as to why they were leaving the unit.

The formalisation of rotating staff onto the wards was also discussed with management, but it was not clear whether this had started. This meant that the same staff would be used to cover the
same wards of the hospital, so that staff became familiar with the environment, staff and equipment. This was to protect the staff from feeling vulnerable and allow them to be more confident about where they were being used within the hospital. Management were hoping that this would improve morale.

Staff said they felt supported locally and understood that the movement of ICU/HDU staff to other wards was a trust wide issue.

Staff we spoke with said there was a good team spirit within the unit.

Management insured that all staff had appropriate breaks and there was an emphasis on the well-being of staff. Trainee nurses said in a quality panel report, that the study leave for education was encouraged and easily taken.

The unit awarded staff for good attendance and we saw two staff awards presented to critical care staff for 100% attendance between April 2016 and March 2017.

The unit had low reporting of incidents and management stated that they believed this was due to nursing staff believing reporting incidents was linked to ‘blaming’ staff. We were told that work and re-training had been carried out to educate staff on incident reporting. They had since seen an increase in reporting.

We saw good communication amongst the nursing staff and management looked at new ways of communicated to staff. A recent method of communication was via a closed social media site, where staff could view relevant work information, including; availability of extra shifts and any relevant new guidance and policies.

**Governance**

The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service had back up emergency generators in case of failure of essential services and had experienced a power cut at the hospital in 2017. Prior to this incident a ‘table top’ emergency meeting had been held where discussions and actions were talked through in preparation for a major incident. The unit had major incident action cards which were accessible via the intranet in case a major incident was declared. There were also paper copies available in case the IT systems went down. However, staff we spoke with were not aware of the process for a major incident and we were informed by management that there had not been any staff training.

Information technology downtime packs were available, in the case of the main computer system failing or being corrupted. Two special computers, which contained passwords, were available in a locked cupboard

A senior staff meeting was held monthly, bringing together consultants, radiographers and office managers. They discussed issues and provided information to changes, events and presented any new guidance. We spoke with senior staff members who said that everyone is given a chance to contribute and it feels like a true team meeting. The minutes to the meeting were made available on the shared drive. We attended a morning staff meeting during our visit and saw that it was well attended. This had improved since the last inspection.

**Management of risk, issues and performance**
The unit had an active risk register, which had 11 live risks listed, however a number of the risks had been on the risk register for over 12 months. There were actions identified to mitigate the risk. At the last inspection in 2015, the unit did not have a risk register. The risk register needed to time mature as we were not assured that all risks were being identified in a timely way.

The existing facilities for ICU and HDU were recorded on the risk register. It was reported that they did not comply with HBN 04-02. However, the hospitals did not indicate when facilities would be upgraded. There had been an action to put in place a standard operating procedure to ensure there were adequate spaces between beds, but it had been reported this was not necessary. The risk had not been escalated onto the corporate risk register.

We saw copies of a ‘learning lessons safety bulletin’, produced for the nursing staff by the critical care lead. The bulletin was informative, easy to read and well thought out. We saw that a note had been added to staff with regards to reporting incidents. This was reassuring staff that it was okay to report incidents after there had been a low reporting period.

In the ‘learning lessons safety bulletin’ for August to October 2017, it was highlighted to staff that there were cases when pressure ulcers were present prior to patients being admitted to the unit and this had not been documented. It evidenced that there had been local reviews as a result and learning points.

**Information management**

There were effective arrangements to ensure that data or notifications were submitted to external bodies. The unit took part in local and national audits, including the Intensive Care National Audit and Research Centre (ICNARC). The unit had a dedicated ICNARC clerk who collated all relevant information and submitted the evidence to ICNARC every quarter.

Moving from paper patient records to electronic records had been a big change for the staff in ICU, however they told us they were seeing the benefits for the safety of the patients. The electronic system flagged up trigger factors and recently the system had indicated that nurses were failing to check patients for delirium. A number of nursing staff told us this was due to where the check box/prompt was located on the patient records. The practice educators approached staff in ICU/HDU and conducted re-training on where to find it on the system.

**Engagement**

There had been a recent staff survey however we had not been given the results at the time of our inspection.

All management we spoke with were aware that staff morale had been low over the previous two years, but felt it was improving. Nursing staff had previously not been involved in any daily communication meetings and now that they were part of the morning huddles. The huddles discussed topics such as patients with ‘do not attempt cardiopulmonary resuscitation’ forms (DNACPR), staff capacity, allergic patient safety issues and incidents from the previous 24 hours etc. Nurses told us they felt more informed since becoming part of the huddles.

The matron fed back to staff via a quarterly ICU newsletter, which was sent to all staff. There was also a closed social media group where incidents, new guidance and changes to legislation were shared.

Trainee nurses were asked to present the monthly morbidity and mortality meetings for the unit. On feedback received from the quality panel, nurses had said they enjoyed this responsibility.
Learning, continuous improvement and innovation

There were robust systems and process for learning and continuous improvement.

A weekly safety summit was held and attended by a mix of clinical and nursing leads and managers, trust wide, though we were informed that the meetings were open to all staff. We attended a safety submit and listened to the top two risks and incidents being shared and discussion about lessons learnt. The ICU lead shared an issue concerning discharges and how to make them safe. Some incidents resulted in information being shared to all staff electronical via ‘safety bites’ and shared at staff handovers. The spirit of the safety summit was ‘what we can do today and share tomorrow’.

We were informed of an incident regarding total parenteral nutrition (TPN) (the feeding of a person intravenously). This was administered to the wrong patients and the wrist band for identification wasn’t checked. We saw evidence that it had been investigated and duty of candour was carried out. A local review was being conducted. A safety alert was sent to the nursing staff making them aware of the incident and nurses attended safety intravenous drugs training.

The clinical librarian had been working on a project to increase the knowledge for ICU staff on various related subjects. A relevant critical care topic would be chosen by them each month and shared with staff on a closed social media group. We were told that this had received a good response.
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.

Maternity

Facts and data about this service

Wirral University NHS Trust has 47 maternity beds at Arrowe Park Hospital. These consist of ward 53, the combined antenatal and postnatal ward (32 beds), labour ward (10 beds) and the alongside midwife-led unit, Eden Suite (five beds). The unit also facilitates a home birth service and is due to open a standalone “pop up” birth centre.

(Source: Routine Provider Information Request (RPIR) P2 – Sites)

From October 2016 to September 2017, there were 3,115 births at the trust.

A comparison of the number of births at the trust and the national totals over the most recent 12 months is shown below:
The profile of all deliveries from October 2016 to September 2017 can be viewed below. The trust had a similar profile of births in terms of single and multiple births, mother’s age and gestation when compared to the national profile.

Table 1: Profile of all deliveries (October 2016 to September 2017)

<table>
<thead>
<tr>
<th></th>
<th>Wirral University Teaching Hospital NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deliveries (n)</strong></td>
<td>Deliveries (%)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>3,069</td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>46</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>128</td>
<td>4.1%</td>
</tr>
<tr>
<td>20-34</td>
<td>2,418</td>
<td>77.6%</td>
</tr>
<tr>
<td>35-39</td>
<td>477</td>
<td>15.3%</td>
</tr>
<tr>
<td>40+</td>
<td>92</td>
<td>3.0%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3,115</td>
<td>607,089</td>
</tr>
</tbody>
</table>
## Table 2: Gestation periods (October 2016 to September 2017)

<table>
<thead>
<tr>
<th>Gestation period</th>
<th>Wirral University Teaching Hospital NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>218</td>
<td>7.1%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>2,861</td>
<td>92.8%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

**Total number of deliveries with a valid gestation period recorded**

| Total | 3,082 | 498,097 |

Note: For reasons of confidentiality, numbers below six and their associated proportions have been removed and replaced with ‘*’.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

Trends by quarter for the last two years can be seen in the graph below:

Number of births at Wirral University Teaching Hospital NHS Foundation Trust by quarter

(Source: HES - Births (October 2015 - September 2017)
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 trust set a target of 95% for completion of mandatory training. Training included face to face and e-learning modules.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for nursing and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block B</td>
<td>84</td>
<td>146</td>
<td>57.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>21</td>
<td>39</td>
<td>53.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management Level 2</td>
<td>11</td>
<td>29</td>
<td>37.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>CPR</td>
<td>45</td>
<td>146</td>
<td>30.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block A</td>
<td>32</td>
<td>146</td>
<td>21.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security 1</td>
<td>12</td>
<td>146</td>
<td>8.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Block A contains manual handling, health and safety level 1, risk management level 1, consent awareness, end of life care and moving and handling modules. Block B contains fire safety, infection prevention and control and medicines management modules.

The overall completion rate for mandatory training modules by nursing staff in maternity at the trust was 31.4%. Nursing staff did not meet the trust target for any of the six mandatory training modules.

We were unable to identify the number of medical staff members solely for maternity as the trust informed us that they employ obstetrics and gynaecology staff who cover both roles. Therefore, the following analysis of training for medical staff includes staff working in both maternity and gynaecology.
A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical staff in maternity and gynaecology is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block B</td>
<td>6</td>
<td>16</td>
<td>37.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>CPR</td>
<td>5</td>
<td>16</td>
<td>31.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety Level 2</td>
<td>4</td>
<td>14</td>
<td>28.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Block A</td>
<td>3</td>
<td>16</td>
<td>18.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management Level 2</td>
<td>2</td>
<td>14</td>
<td>14.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security 1</td>
<td>1</td>
<td>16</td>
<td>6.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Block A contains manual handling, health and safety level 1, risk management level 1, consent awareness, end of life care and moving and handling modules. Block B contains fire safety, infection prevention and control and medicines management modules.

The overall completion rate for mandatory training modules by medical staff in maternity and gynaecology at the trust was 22.8%. Medical staff did not meet the trust target for any of the six mandatory training modules.

(Source: Routine Provider Information Request (RPIR) P40 –Mandatory and Statutory Training)

At the time of our inspection mandatory training completion was significantly higher than the information provided before the inspection. We found they had a process in place to work towards the aim that all staff completed it.

Data provided by the trust following the inspection showed the latest available midwifery and obstetric compliance with mandatory and other training which were:

Mandatory training compliance block A (December 2017):
- Maternity medical staff: 75%
- Community midwives: 92.86%
- Hospital midwives: 96.19%
- Community Support worker: 75%
- Hospital Support Worker: 100%

Basic life support cardio pulmonary resuscitation (February 2018):
- Community midwives: 83.33%
- Hospital midwives: 91.18%
We saw evidence, of the “Block C” mandatory training that midwives should attend yearly. The areas covered included sepsis, high dependency unit care, antenatal screening and sexual health.

PROMPT (Practical Obstetric Emergency Multi-Professional Training) Compliance (February 2018)

Community midwives 80.95%
Hospital Midwives 76.84%

Medical devices compliance (February 2018)
Maternity staff 91.88%

The service was replacing block A and B training in the next year and replacing it with individual modules. Training was being streamlined to enable easier transition between trusts, with the possibility of providing shared training in the future.

The service had recently appointed a practice development midwife to monitor the training needs of the service and compliance.

Cardiotocograph teaching sessions were facilitated every Tuesday afternoon by one of the two advanced midwifery practitioners.

Safeguarding

The trust reported that their protecting vulnerable people courses contained safeguarding adults and children modules. Data on the individual modules within these courses was not provided.

The trust set a target of 95% for completion of protecting vulnerable people training.

The breakdown of protecting vulnerable people training completion from April 2017 to October 2017 for nursing staff in maternity at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 3</td>
<td>97</td>
<td>146</td>
<td>66.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 2</td>
<td>97</td>
<td>0</td>
<td>n/a</td>
<td>95%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

The protecting vulnerable people courses contain modules relating to safeguarding adults, safeguarding children, PREVENT (training around the risks of radicalisation and the roles involved in supporting those at risk), Mental Capacity Act, Deprivation of Liberty Standards, domestic violence, Mental Health Act and dementia awareness.

Protecting vulnerable people level 3 training had been completed by 97 of the 146 nursing staff eligible for it (66.4%) in maternity while the trust indicated that no nursing staff were eligible for
level 1 training. However, for level 2 training, they indicated that 97 staff members had completed the module although none were eligible. This suggests possible data quality issues.

At the time of the inspection the safeguarding training had improved significantly from the information provided by the trust.

Safeguarding level 2 protecting vulnerable people (December 2017)
Maternity staff 91.67%

Safeguarding level 3 (protecting vulnerable people) (December 2017)
Maternity medical staff 93.33%
Community midwives 100%
Hospital midwives 98%

We were unable to identify the number of medical staff members solely for maternity as the trust informed us that they employ obstetrics and gynaecology staff who covered both roles. Therefore, the following analysis of training for medical staff includes staff working in both maternity and gynaecology.

The breakdown of training completion from April 2017 to October 2017 for medical staff in maternity and gynaecology at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>13</td>
<td>3</td>
<td>433.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 3</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The protecting vulnerable people courses contain modules relating to safeguarding adults, safeguarding children, PREVENT (introductory training around the risks of radicalisation and roles involved in supporting those at risk) Mental Capacity Act, Deprivation of Liberty Standards, domestic violence, Mental Health Act and dementia awareness.

Protecting vulnerable people level 3 training had been completed by 11 of the 13 medical staff eligible for it (84.6%) in maternity and gynaecology while the trust indicated that no medical staff were eligible for level 1 training. However, for level 2 training, they indicated that 13 staff members had completed the module although only three were eligible. This suggests possible data quality issues.

(Source: Routine Provider Information Request (RPIR) P40 –Mandatory and Statutory Training)

Staff we spoke with 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.

There was no named midwife for safeguarding at the trust. However, there was a trust safeguarding team who support the midwives in their role and led on safeguarding in maternity. They facilitated pre-birth liaison meetings, multi-agency meetings and early help for those that required it. They also facilitated safeguarding supervision to midwives.
The maternity service did not use electronic baby ID and security tagging system. This was documented on the risk register as being due to the inability of the two electronic security systems within the trust to provide an automated alarm alert for unauthorised movement of the baby. However, we reviewed the baby abduction policy, which included a flowchart of what to do and a scribe sheet.

We observed discharges from the unit on the ward. Any safeguarding concerns or plans were clearly documented on the maternity information technology system prompting the relevant safeguarding questions to be asked and plans to be followed. This was an improvement from the last inspection.

We also saw an ‘ABBAB’ (abduction of baby) box, which staff we spoke with knew where it was kept. We were told it was called an ABBAB box so as not to concern parents unnecessarily. It contained a flowchart of what to do, who to call and the escalation guidelines.

During our inspection, we observed that the main entrance door to the delivery suite did not shut completely due to a broken hinge meaning the door did not automatically lock. This increased the risk of unauthorised entry into the unit. We reported this immediately to staff on the first day of our inspection as a security concern. Staff reported the broken door to the maintenance department. However, due to another major incident in a different department, the maintenance team did not fix the door until after day two of our inspection. In the interim, there were no other security precautions taken by the maternity service to ensure the safety of mothers and babies, other than a sign on the door to ask people to ensure it was closed. When this was highlighted to a senior member of staff, we were informed that a member of staff was always positioned at the reception desk to ensure safety. However, we observed on several occasions during our inspection that there was no one sat at reception desk.

We observed on many different occasions during the inspection, that when we used the buzzer system outside the doors of different maternity areas, to gain access, staff released the door without asking who we were and reason for entry. We highlighted this to a senior coordinator. This did not assure us that robust precautions were used to ensure the safety of mothers and their babies and prevent the abduction of babies.

We did not observe any posters displayed near the main entrances to the clinical areas about the risks to tailing/tailgating and allowing other visitors into the ward areas without permission.

One of the trust’s safeguarding team was the named person for female genital mutilation (FGM) and she explained that the compulsory questions were on the maternity information technology system which ensured compliance. There was a process that involved working in partnership with a neighbouring trust to facilitate the most appropriate care.

**Cleanliness, infection control and hygiene**

There were not always cleaning schedules in all areas, not all equipment had I am clean stickers on and staff and relatives entered obstetric theatres with outside footwear. Drug fridges were not checked consistently and were not always secure or clean and it was some equipment appeared not to have been checked or serviced adequately. Staff rooms were not clean, had broken equipment in them and appeared generally unkempt.

The trust had an infection prevention and control policy. We observed that most staff complied with the policy and principles for preventing and managing infections.

We were informed that there were no cases of Clostridium difficile or methicillin-resistant Staphylococcus aureus in the twelve months before the inspection.
When women were booked into the service they were recommended to ask their GPs for their influenza and Pertussis vaccinations.

We observed relatives and staff wearing their own footwear, without overshoes, in the operating theatre. This was not in accordance with good practice. This was also escalated to the labour ward lead midwife who stated she would look into this issue.

There were no visible cleaning schedules in staff toilets.

The service undertook audits of infection control. The results were displayed on notice boards on the wall at the entrance to clinical areas. Information regarding an infection control audit carried out in 2017 highlighting 87% compliance which was displayed as “Gold Status”.

There were wall-mounted hand washing solutions at clinical sinks and there were wall-mounted hand gels on entrances to clinical areas and in other relevant areas and we observed staff and visitors using these.

We saw “I am clean stickers” on some equipment in the unit to identify when cleaned and ready for use. However, these were not used in every area of the service. We observed areas such as the Eden suite where these stickers were not used.

Staff followed the trust’s dress code and were “bare below the elbows” in the clinical areas.

All sharps bins we saw were not filled above the advisory level and used appropriately.

The privacy curtains in areas such as the Eden suite were cloth with indication when they were last changed or due to be changed. There was no formal document which recorded this.
Environment and equipment

The trust did not have a baby tagging system meaning that when the door security was faulty babies safety was compromised. Staff did not always check who was entering or leaving the clinical area, further compromising safety of both mums and babies. Drug fridges were not checked consistently and were not always secure and some equipment appeared not to have been checked or serviced adequately. Staff rooms were not clean, had broken equipment in them and were generally unkempt. Low risk women had their labours induced in a single room on the ward area and as such staff were unable to observe theirs and their unborn wellbeing adequately. There were occasions where midwives had to recover women following an emergency caesarean section and it was questionable whether they were competent in this practice. Labour ward leaders were not always supernumerary and an induction of labour was delayed due to access and flow issues. There was an ongoing connectivity issue inhibiting community midwives from updating the maternity information technology system or taking booking bloods in a timely scale.

Entry to the core clinical areas was via a controlled access system in order to monitor staff, patients and visitors. However, at the start of our inspection we observed a broken door to the labour ward area that compromised this secure access. We highlighted this to staff and it was fixed during the inspection.

The maternity unit had a triage area which had two rooms and was open 24 hours a day by one midwife, seven days a week. Women were encouraged to telephone this number if they thought they were in labour or were concerned regarding the pregnancy and needed to be reviewed by a midwife or obstetrician.

Adjacent to this area was an antenatal clinic, obstetric scanning facilities and a maternity day unit.

There was one antenatal and postnatal ward with 32 beds, all of which we observed were single room facilities. Some of the rooms were used as transitional care beds (for babies who needed extra care, but who did not need to be cared for in the neonatal intensive care unit) when staffing allowed. This meant less separation of mother and baby.

Low risk inductions of labour were currently carried out on ward 53.

There was an infant feeding room in this area which had keypad access. Within this room, there was a fridge in which expressed breast milk and donor expressed breast milk was stored in separate bottles. We observed all these bottles were dated and labelled appropriately. We observed that the fridge temperature had been checked on 67 of the last 73 days before our inspection. There were three breast expressing pumps for women to use.

The labour ward had 10 beds, one of which was undergoing refurbishment during our inspection to be the allocated bereavement room and another had a birth pool.

The alongside midwife-led unit, Eden Suite, had five beds, two of which had birthing pools, and the “Snoozle room”. This room was used by women not yet in established labour who would normally return home, but who preferred to stay within the confines of the maternity unit.

We were told that the midwife-led unit had not been closed to admissions since July 2017 and that if the unit was full, then low risk women had to birth their baby on the labour ward.

The unit had appropriate equipment in all areas such as neonatal resuscitaires, cardiotograph machines and blood pressure taking equipment. However, whilst some had asset numbers and the date of the next service, other pieces of equipment did not. We saw two pieces of equipment,
weighing scales and an oxygen saturation monitor, being used in the obstetric theatre that were overdue to be calibrated or had no service or calibration date and no asset number. Both of these issues were brought to the attention of the midwife prior to commencement of the next elective caesarean section. When we asked about this we were told that the servicing was carried out centrally and that there was a central record of what was due and when.

We observed the staff room on the ward area during our inspection. The water heater was not working and had reportedly not worked for approximately four years. Staff told us that they had to share the tea and coffee making facilities with the inpatients and visitors which was situated on the corridor. The fridge appeared dirty and there was a lack of cutlery or plates with which staff could eat their meals. Staff told us that the room was not fit for purpose and it had an impact on their wellbeing.

We saw that an unlocked fridge on the midwife-led unit which contained oxytocic drugs, milk and milkshake. This was highlighted to staff. We also saw that the temperature of the fridge had not been checked daily. It had been checked 33 days out of the last 73.

Women and their families who experienced pregnancy losses were cared for in one room on the labour ward until the dedicated bereavement room was completed.

There were two obstetric theatres located next to the labour ward for ease of access, if needed. Women who underwent caesarean sections were recovered in the immediate postnatal period in a dedicated recovery area on labour ward.

The unit also facilitated a home birth service and was due to open a standalone “pop up” birth centre (pop up birth centres are part of the action plan pilot to provide birthing centres where required, near to women’s homes).

We saw an emergency equipment box which community midwives were allocated. We reviewed an audit, whereby the team leader carried out spontaneous checks of these boxes to ensure that they were both complete and that the medication within was in date. This was an improvement from the last inspection.

The service had a home birth guideline that highlighted that all equipment being sent to the woman’s home in preparation for the home birth, including Entonox and oxygen cylinders, were checked and signed off for appropriateness and transport to the woman’s home by two midwives. Midwives transporting the equipment must comply with the risk assessment for transportation and display a compressed gas warning sign in their car. They also must ensure the woman is given the storage of cylinders leaflet. This leaflet highlighted information such as where to store the cylinders, the temperature and no smoking in the area and the need to inform the woman’s insurance company. This was an improvement from the last CQC inspection.

**Assessing and responding to patient risk**

Women undergoing an induction of labour were cared for on the combined antenatal and postnatal ward, which was situated on a different floor to the labour ward. We were assured that the clinician booking the woman carried out a risk assessment to ascertain whether this should be carried out on the ward or labour ward.

Staff told us, that there was no dedicated area on the ward and women were cared for in single rooms by midwives who were also caring for other patients. Midwives and medical staff told us that even though being cared for in a single room increased the patient experience, there were some safety concerns as women were not always visible and continuously monitored by staff. There had been one incident in October 2017 with a woman who needed transferring to labour ward quickly, but that there was a delay in transferring.
This had been investigated and discussions were taking place within the trust to permanently move the induction of labour women and process to the dedicated area, with allocated staff, on the delivery suite to reduce safety concerns. Staff informed us that no formal risk assessment had been completed for the current set up and it was not on the maternity risk register.

During the inspection, there were planned elective caesarean sections carried out. Prior to the women being brought to the theatre, we observed the “safety huddle” where they discussed each woman and any concerns or risks pertaining to her case.

There were obstetric handovers three times per day to continually ensure that any risks or issues in the unit were addressed and handed over to the obstetricians taking over care.

During our inspection, we were informed that there was only one theatre team for the whole hospital out of hours. This meant that if an emergency caesarean section were needed, the scrub nurse and recovery team would have to attend from the main part of the hospital. However, we were told by members of staff that sometimes midwives had to recover women following such a caesarean section, which is something that they were not trained to do. We were told that this was on the risk register, but the copy we were given, produced on 12 March 2018, had no reference to this risk. During the inspection we were told that it would be on the risk register by the end of the week. We reviewed a completed risk assessment form which detailed the current risk of the expectation of registered midwives to recover women whom had undergone emergency procedures and that there were very few midwives who possessed the required knowledge, skill and competency. It is also highlighted on this form that this was against national guidance that the delivery suite sister was to ensure that only experienced midwives were to provide recovery of such women. Furthermore, that the new theatre manager and matron was to review current staffing to enable a recovery nurse to cover the maternity theatres 24 hours a day seven days a week.

We had received assurances from a senior member of the team that where there were no recovery staff available, the anaesthetist would recover the woman until transferred to the ward area. However, we spoke to members of staff who stated that this was not always happening and that midwives not competent in this speciality were still having to recover such women.

We were also told of plans to improve patient experiences by such initiatives as devising a standard operating procedure highlighting clear guidance on care for post-operative patients and a self-assessment document to support professional development.

There were emergency procedure proformas in each of the clinical rooms in the event of certain emergencies, such as post-partum haemorrhage or shoulder dystocia. However, there were no version or review dates on any of these sheets highlighting when they were to be reviewed. This was highlighted to staff.

We viewed the home birth guideline which highlighted that the labour ward lead should be informed when any of the community midwives leave home to attend a home birth, the address to which they are attending, and also when they return home following this, as per the lone worker policy. We observed evidence of this in action on the labour ward white board whereby the labour ward lead had documented that midwives were attending a home birth. However, the community midwives were not supplied with a lone worker device and none of the labour ward leads or other midwives we spoke with were aware of any process to check on the welfare of the midwives at homes births in between these times.
**Midwifery and nurse staffing**

The trust reported the following nurse staffing numbers for maternity at Arrowe Park Hospital in March and October 2017. The service had a fill rate of over 90% in both periods.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Actual WTE Staff in post</th>
<th>Planned WTE staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>128.3</td>
<td>133.6</td>
</tr>
<tr>
<td>October 2017</td>
<td>130.7</td>
<td>139.2</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The service had, on most occasions, enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. For two of the three days of our inspection the transitional care unit was not open to admissions due to inadequate skill mix of staffing and the neonatal unit was closed to admissions.

The planned staffing rates were aligned with a recognised and recommended staffing tool. We observed that staff were moved to the areas of most need when the actual staffing numbers differed, such as due to sickness.

There were systems in place for midwives to book bank shifts. However, staff reported this was confusing and had led to shifts being double-booked.

We were told that the labour ward co-ordinator was supernumerary. However, on one occasion we observed that one woman whom was experiencing pregnancy loss at an early gestation was being cared for by the labour ward co-ordinator on the labour ward due to capacity issues elsewhere.

There was an on call system whereby a community midwife could be requested to support the unit, if necessary.

There was a closed page on a social media website that staff were encouraged to access on which midwives were able to request shift swaps with colleagues.

During the inspection we identified an issue involving a woman’s induction being delayed from starting for two days as there was inadequate staffing for the transitional care area and the neonatal intensive care unit was closed to new admissions.
Vacancy rates

From November 2016 to October 2017, Arrowe Park Hospital reported a vacancy rate for nursing staff in maternity of 6.4%. The trust does not have a target vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

We were informed by a member of the senior maternity team, that they were currently approximately 82 midwifery hours outstanding and approximately 40 clinical support worker hours short. There were plans already in place to recruit to the vacant posts.

Turnover rates

From November 2016 to October 2017, Arrowe Park Hospital reported a turnover rate of 4.3% for nursing staff in maternity. This met the trust target of the turnover rate being less than 10%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From November 2016 to October 2017, Arrowe Park Hospital reported a sickness rate for nursing staff in maternity of 6.1% which was higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

From November 2016 to October 2017, the trust reported 947 shifts filled by bank staff (3.1%) and no shifts filled by agency staff in maternity at Arrowe Park Hospital. There were 403 shifts not filled by bank or agency staff (1.3%).

A breakdown of bank and agency usage by staff type is shown below:

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>486 (5.0%)</td>
<td>461 (2.2%)</td>
<td>947 (3.1%)</td>
</tr>
<tr>
<td>Agency</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>101 (1.0%)</td>
<td>302 (1.4%)</td>
<td>403 (1.3%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)
Midwife to birth ratio:

From October 2016 to September 2017, the trust had a ratio of one midwife to every 24.28 births. This was similar to the national rate of 26.82.

(Source: Electronic Staff Records – EST Data Warehouse)

Since the last CQC inspection in September 2015, the electronic staff rostering processes had improved. However, we saw evidence that the staff allocation process caused confusion.

We observed at a morning handover staff not knowing what clinical areas they were assigned to work in and had moved between different clinical areas before the day started. Staff told us that it was normal for some staff to use their closed social media page to ask where they were working the following day as there were often last minute changes to the staff rota due to skill mix, sickness and workload. Staff told us that they found this increasingly frustrating and annoying. We were also informed that staff sometimes changed shift rotas between themselves last minute, and that authorisation had not gone through the formal processes with their managers or shift co-ordinators.

Managers were aware of the allocation problems and encouraged all staff to follow the correct processes for changing shift rotas. There was a “swap” folder that they could complete that was monitored and authorised by matrons and managers and staff could use the closed social media format to request shift changes. However, the managers were working towards ensuring that they had the right staff in the right area at the right time, dependant on acuity, which was why they rotated staff to differing areas from those allocated on the health roster system.

We were given the minutes of Royal College of Midwives union meeting held on 15 January 2018 to discuss issues staff had with electronic rostering. Issues recorded on the minutes included being rostered to work more than four nights in a row. The E roster recommendation was for the staff member completing the roster to look at the previous one to see what the last shift work had been and to also put an alert onto the system for when five nights together was allocated. Staff were also unable to request shifts off, only the full day. However, it was documented that this had been resolved.

Senior managers told us that no formal action plan was formulated following the meeting or lead persons assigned to address the issues that were discussed at the meeting.

The trust main theatre recovery team did not have the full establishment to cover out of hours emergency maternity cover to recover an emergency maternity patient. At night, there was only one recovery practitioner on night duty who was on duty to cover the emergency theatre patients in the main trust theatres. This matter was being discussed at senior level who responded to our concerns during the inspection. The trust informed us that between December 2017 and March 2018 of the 55 out of hours emergency caesarean sections performed there have been 12 incidents reported relating to lack of appropriately trained staff on the maternity theatre, including where recovery staff were not available to support the recovery phase of care.

We spoke to some community midwives who explained that the team structure had recently changed from three teams for the geographical area to two to allow for the new Highfield home birth team to be established. This meant that there were a group of women who were not receiving continuity of care. The midwives said they were invited to regular meetings about the changes to community services. They also said they were very busy, especially those who had complex child protection issues on the caseload. However, they all felt that they were fully supported by their team leaders.
Medical staffing

We were unable to identify the number of staff members solely for maternity as the trust informed us that they employ obstetrics and gynaecology staff who cover both roles. Therefore, the following analysis includes medical staff working in both maternity and gynaecology.

The trust reported the following medical staffing numbers for maternity and gynaecology at Arrowe Park Hospital in March and October 2017. The service had a fill rate of around 60% in both time periods.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Actual WTE Staff in post</th>
<th>Planned WTE staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>17.1</td>
<td>28.2</td>
</tr>
<tr>
<td>October 2017</td>
<td>17.1</td>
<td>28.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From November 2016 to October 2017, Arrowe Park Hospital reported a vacancy rate for medical staff in maternity and gynaecology of 28.9%. The trust does not have a target vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From November 2016 to October 2017, Arrowe Park Hospital reported a turnover rate for medical staff in maternity and gynaecology of 11.6%. This was higher than the trust target of having a turnover rate less than 10%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From November 2016 to October 2017, Arrowe Park Hospital reported a sickness rate of 3.1% for medical staff in maternity and gynaecology which was lower than the target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and locum staff usage

From November 2016 to October 2017, the trust reported 104 shifts filled by bank staff and 90 shifts filled by medical locum staff in maternity and gynaecology at Arrowe Park Hospital. There were seven shifts not filled by bank or agency staff.

A breakdown of bank and locum usage by staff type is shown below. Please note that the trust did not provide the total shifts available for middle grade doctors so we are unable to calculate bank and locum usage overall or for this staff type as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Consultant</th>
<th>Middle grade</th>
<th>Doctor in training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>0 (0.0%)</td>
<td>13</td>
<td>91 (1.7%)</td>
<td>104</td>
</tr>
<tr>
<td>Locum</td>
<td>71 (1.8%)</td>
<td>19</td>
<td>0 (0.0%)</td>
<td>90</td>
</tr>
<tr>
<td>Not filled</td>
<td>6 (0.2%)</td>
<td>1</td>
<td>0 (0.0%)</td>
<td>7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

As of October 2017, the proportion of consultant staff reported to be working in maternity at the trust was slightly lower than the average for England while the proportion of junior (foundation year 1-2) staff was similar.

Staffing skill mix for the 29.7 whole time equivalent staff working in maternity at Wirral University Teaching Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>46%</td>
<td>46%</td>
</tr>
<tr>
<td>Junior*</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ 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)
We observed a medical handover. Doctors of different grades and professions attended and we found it to be well structured, clear and comprehensive.

Obstetric registrar and obstetric consultant covered both labour ward and gynaecology on call emergencies. However, we were informed that labour ward took priority if an emergency arose and that there had been no issues or problems with this model of working. The obstetric middle grade doctors covered maternity only in working hours.

There was no dedicated obstetric cover for the triage area meaning that there were sometimes delays in the timeliness of reviews of women. Therefore, we were told about plans to introduce a “red flag” system to help mitigate this. A red flag is a warning to staff that something needs escalating, for example a raised temperature may be a sign of infection that would need a doctor’s review.

Consultant obstetrician cover for the labour ward was 60 hours per week per week, 8.30am until 7.30pm and 5 hours at the weekend which met national guidance.

We were told that there was no issue with obstetric registrar cover as “they want to come and work here”.

The consultant obstetrician could be contacted directly by any midwife if they disagreed or were unhappy with the plan of care.

**Records**

Staff mostly kept appropriate records of patients’ care and treatment. Records were clear, up to date and available to all staff providing care. Women’s maternity records were not kept securely on the wards and there was an ongoing connectivity issue inhibiting community midwives from updating the maternity information technology system or taking booking bloods in a timely scale.

We observed that behind each of the midwife’s stations on the ward area there were storage facilities such as lockable trolleys or cupboards where women’s confidential pregnancy and birth records were stored. However, at all stations we observed that these locks were either broken or unlocked and unattended, and therefore not secure and accessible to all. Staff told us that a member of staff was always in attendance. However, we observed instances where the stations were unattended.

We reviewed the maternity electronic record system and sample of records which were all up to date. This included the ‘situation, background, action, recommendation’ or SBAR handover which was on the system, which were also a paper document of this. Personal child health records also known as the “red book” were given to the parents of each child at the first neonatal check. However, we observed that the safe sleeping section of this book was not completed in the records viewed despite this subject being discussed with the parents.

We saw five care plans on the postnatal ward area, all of which appeared complete and up to date.

Most of the care records of mothers and babies were inputted onto the maternity electronic records system. However, due to a connectivity issue with the information system it meant that the community midwives could not connect their tablet computers to the maternity information system and all women were discharged with paper notes. We saw evidence that this issue was on the risk register and that a postnatal template had been built ready for when it had been solved. However, at present there were issues such as storage of these notes. This created a risk for any woman who was readmitted following discharge from midwifery care, as the latest episodes of care may not be accessed by the attending health professional.
We were informed that women who attended the antenatal clinic had their consultation details inputted onto the maternity electronic records system by the obstetrician contemporaneously, thus ensuring that the named midwife had access to up to date care plans.

For their hand held notes, women had a 'co-op card' upon which were documented screening test results, expected due date and their customised growth chart.

The service carried out a quarterly medical record keeping audit for obstetrics. Whilst this audit highlighted that they were mostly compliant with the applicable standards, they were non-compliant in three areas which included SBAR (situation, background, assessment, recommendation) which is a tool to facilitate accurate and effective handover between staff. A robust action plan was devised to attempt to ensure compliance with this also.

The service told us that there was an information technology issues with connectivity that prevented community midwives printing off the requisite blood forms. We were told of a temporary arrangement the maternity department have put in place whereby women had their booking bloods taken whilst attending for their dating scan at about twelve weeks. This did not mean another journey for the woman to the hospital. However, it led to a delay in the initial screening tests and potentially a delay in any treatment deemed necessary. We were told that this issue was on the risk register. However, the risk register that we were provided with had no documented evidence that this was a risk. It was, however, highlighted regarding the connectivity issues and the fact that duplication of administration tasks had to be carried out as a result.

Medicines

The service mostly prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

The maternity wards used a paper drug charts. We reviewed 11 drug charts and saw appropriate documentation of allergy status in all records. There was input from a ward pharmacist and evidence of medicines reconciliation. We identified a drug chart that required a review, an increased dose had been prescribed and the lower dose had not been stopped. It was also not clear whether two doses of a second drug had been administered when only one dose was prescribed.

We saw documentation in three of the drug charts to say medication was given under the authority of patient group direction. A patient group direction, signed by a doctor and agreed by a pharmacist, can act as a direction to midwives or nurses to supply and/or administer prescription-only medicines to patients using their own assessment of patient need without necessarily referring back to a doctor for an individual prescription. The medication would have been given as a midwife exemption. The midwife exemptions policy had just been reviewed by the trust and was due to go to the March drug and therapeutic meeting for approval.

The ward had a patient group direction folder. This held paper copies of the relevant patient group directives for use on the ward. The trust had a single signature sheet that covered patient group directives in the trust this was signed by staff and clinical managers. It was not clear which patient group directives this form covered and in line with national guidance we requested that this sheet was reviewed. The trust had updated this guidance and were taking it to the March drug and therapeutics meeting for approval.

We observed a baby being given an intra muscular injection of Vitamin K before it was weighed. The dose of this medicine is dependent upon the baby’s weight as stated in the local guideline. This was brought to the attention of the labour ward lead immediately.
We were informed of a change in practice that was initiated following complaints about late medication administration. The practice of women self-medicating on the wards was initiated to avoid delays and subsequent complaints. However, one woman we spoke with said she kept having to ask for iron tablets, was never offered the self-medication option and had someone else’s medication left in the open medication in her room. We highlighted this to the service during the inspection. We were informed that the practice of self-medicating had only commenced in February 2018 so was not fully embedded.

There was evidence of the trust self-medication policy documentation on the ward, however the two midwives we spoke to were unsure of this policy. There was self-medication paperwork for one patient in the drug chart file, but this was incomplete.

The service had trained 58 midwives on the wards to administer intravenous antibiotics to babies on the postnatal ward/transitional care unit thus preventing the separation of baby from mother whilst receiving this medication on the neonatal unit.

We were told of plans to move towards electronic prescribing for medication. However, whilst staff felt that this initiative was moving forward, the information technology system was causing some delays.

There was only one midwife who could administer a BCG injection to eligible babies prior to discharge home, but the aim was to train midwives to administer this to eligible babies at the newborn infant physical examination check prior to discharge.

We observed that the drug fridges on labour ward were locked and in a locked room and that the temperature of both fridges had been checked daily. None refrigerated drugs were also kept in this locked storeroom. The adult resuscitation trolley on labour ward had the drugs in sealed containers and had been checked daily.

Medication that community midwives carried for emergencies was taken in individual red boxes that were made up by the trust’s pharmacy team and were sealed and dated. Midwives were told to have their boxes replenished and resealed if opened and used. We observed two of these boxes that were sealed and in date.

We reviewed the controlled drugs for the ward. We checked stock for three items and found the balance was correct and the register was properly completed. We saw evidence of a controlled drug audit by the pharmacy team.

The treatment room held a pharmacy information board clearly stating who the ward pharmacist and technician were and how to contact them.

There was a pharmacist attached to the maternity ward. We saw evidence of clinical checks and checking of venous thromboembolism the discharge prescriptions were clinically checked and VTE re-checked. The maternity wards had access to a satellite pharmacy, which supported timely provision of discharge prescriptions.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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.
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 January 2017 to December 2017, there were two incidents which were classified as never events for maternity at the trust. The never event classification in both cases was ‘retained foreign object post procedure’.

The first never event occurred in March 2017 and related to a swab being left inside the patient.

The trust was notified of the second never event in September 2017. Part of a retained drain was found in the patient’s abdomen when they had a procedure carried out at another hospital.

(Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017)

We reviewed the root cause analyses into both of these events and found both to be robust and both had pertinent learning to be taken from them in the form of action plans. We observed this new learning in action following an elective caesarean section where robust and thorough checks were made to prevent further never events occurring.

We reviewed a further root cause analysis regarding a woman undergoing an induction of labour and fetal compromise. This analysis was also thorough with pertinent learning points and an action plan which included adding human factors training to the mandatory training for staff, ensuring adequate handover especially in an emergency and plans to gain funding for a centralised induction of labour suite on the labour ward.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, there were eight serious incidents (SIs) in maternity at the trust which met the reporting criteria set by NHS England from January 2017 to December 2017. All of these incidents occurred at Arrowe Park Hospital.

Of these, the most common types of incident reported were:

- Maternity/obstetric incident: mother only (three incidents)
- Maternity/obstetric incident: baby only (this includes foetus, neonate and infant) (two incidents)

(Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017))

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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.

All of the staff we spoke with were aware of how to report an incident utilising the care importance forms. We observed a list on the wall on ward 53 entitled common care importance forms. This information sheet was not dated but it highlighted a list of 31 common care importance forms such as “baby abduction” and “undiagnosed breech at delivery”.

Of the staff we spoke with, all stated that they received feedback from all reported incidents via email, whether they had reported them or were personally involved. We were informed about a weekly care importance forms meeting that all staff were invited to attend to discuss incidents of the previous week. We saw several editions of the “maternity services news brief” which was
distributed every two weeks. Within these publications, we saw feedback from incidents. For example, it detailed any woman who had contacted triage three times in the last 24 hours must be asked to come in for review. This had been initiated following incidents relating to this. Also, there has been a change to the discharge summary following incidents where women were admitted or had not had their sutures removed in an attempt to address this issue.

We were informed that following a series of incidents with the late administration of intravenous antibiotics, the role of maternity support workers were used to assist midwives in caring for these babies. However, we were also informed that there were only four whole time equivalent maternity support workers meaning that the postnatal ward and transitional care area could not be covered 24 hours a day, seven days per week.

During our inspection we observed a trust wide "safety summit." which was attended by a large number of staff of all grades and professions. This was a weekly meeting to discuss incidents that had been reported in the previous week that would still be investigated, but the aim of the meeting was “What can we do now and communicate tomorrow?” There were three incidents discussed at this meeting; one of which was maternity related. Each incident was presented by staff representatives from the relevant department and all staff were congratulated and celebrated for reporting the incidents. All present were then invited to discuss and contribute to immediate solutions in an attempt to prevent reoccurrences. The maternity incident was relating to suturing and we were informed that both hard copies and emails would be forwarded to all staff in a “safety bites newsletter.” There was a no blame culture observed throughout.

We reviewed copies of the weekly “Learning from care improvement forms” information that was forwarded to staff in a variety of formats and within which was highlighted incidents reported in the last week and actions taken for each one.

**Safety thermometer**

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

We saw “proud to care for you” notice boards on the wall at the entrance to the clinical areas which included the Safety Thermometer for the period October to December 2017. Displayed on the boards was information including Maternity Incident Trends, including unexpected term admissions (34), communication failures (18), post-partum haemorrhage >1500mls (17), staffing issues (14) and delay to treatment (13). Also observed on this notice board was information regarding an infection control audit carried out in 2017 highlighting 87% compliance which was displayed as “gold status”.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. The service carried out audits to ensure both compliance and effectiveness of care provided.

Staff used guidelines from the National Institute for Health and Care Excellence and the Royal Colleges as a basis to determine the treatment they provide.

We reviewed a variety audits, some ongoing, that were used to benchmark their performance against national guidelines and to highlight areas for improvement. These audits included medical record keeping, induction of labour, missed case of small for gestational age, stillbirth and modified early obstetric warning scores.

Copies of policies and guidelines were available to all staff via the trust intranet.

There were specific care pathways for certain conditions such as reduced fetal movements, admission criteria for the neonatal unit and transitional care to improve the standard of care to standardise and improve the care for women.

We saw evidence of the work that the department was involved in with other trusts within their region to benchmark and standardise care provision.

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 women’s religious, cultural and other preferences.

The trust had achieved the UNICEF level 3 breast feeding status and had been reaccredited in 2017. We were informed that this was achieved by having a dedicated infant feeding support team working with staff and a local charity to offer continued support. We observed the infant feeding support team supporting women to feed their babies.

The trust employed a breastfeeding specialist midwife.

In January 2018, the trust reported a 63% breastfeeding initiation rate, which is 5% higher than the target set by the local clinical commissioning group.

The service referred to the ‘magic hour’ as a prompt for staff to achieve this result. The magic hour refers to the one hour uninterrupted skin-to-skin immediately following birth which is important in the initiation of breastfeeding and has other benefits to both mother and baby.

Tea and coffee facilities were easily accessible 24 hours a day for women and their partners.

We spoke to one mother whose baby had been birthed prematurely and had been readmitted for treatment. Women told us that breast feeding and support was positive.

Pain relief

Staff managed pain well. Women had access to a variety of analgesia in labour if they wish, including relaxation and hypnosis, paracetamol, Entonox, pethidine and diamorphine.

Women had access to epidural analgesia 24 hours a day, seven days a week.
Eligible women were prescribed medication that was then placed in a locked cabinet by their bedside to avoid unnecessary delays in accessing pain relief.

Alternative forms of pain relief were available including the use of birthing pools and aromatherapy.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared some local results with those of other services to learn from them.

**National Neonatal Audit Programme**

In the 2017 National Neonatal Audit, based on data for January 2016 to December 2016, the trust performance was as follows:

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 99 eligible mothers identified for inclusion in this audit measure, 87% of which were given a complete or incomplete course of antenatal steroids. This was within the expected range nationally and above the national aspirational standard of 85%.

Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 38 babies identified for inclusion in this audit measure, 66% of which were given magnesium sulphate in the 24 hours prior to delivery. This was in the top quartile when compared to other trusts nationally.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

**Standardised Caesarean section rates and modes of delivery**

From July 2016 to June 2017 the standardised elective, emergency and total numbers of caesarean sections at the trust were all similar to expected:

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England Caesarean rate</th>
<th>Wirral University Teaching Hospital NHS Foundation Trust Caesareans (n)</th>
<th>Caesarean rate</th>
<th>Standardised Ratio</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective caesareans</td>
<td>12.1%</td>
<td>350</td>
<td>11.3%</td>
<td>96.6 (z=-0.3)</td>
<td>Similar to expected</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.4%</td>
<td>415</td>
<td>13.3%</td>
<td>87.3 (z=-1.0)</td>
<td>Similar to expected</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>27.5%</td>
<td>765</td>
<td>24.6%</td>
<td>91.3 (z=-1.2)</td>
<td>Similar to expected</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.
In relation to other modes of delivery from July 2016 to June 2017, the table below shows the proportions of deliveries recorded by method in comparison to the average for England. The trust had a high proportion of non-interventional deliveries when compared to the national average.

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Wirral University Teaching Hospital NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries</td>
</tr>
<tr>
<td>Total caesarean sections(^1)</td>
<td>765</td>
<td>24.6%</td>
</tr>
<tr>
<td>Instrumental deliveries(^2)</td>
<td>305</td>
<td>9.8%</td>
</tr>
<tr>
<td>Non-interventional deliveries(^3)</td>
<td>2,032</td>
<td>65.3%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>8</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>3,110</td>
<td>100%</td>
</tr>
</tbody>
</table>

\(^1\)Includes elective and emergency caesareans  
\(^2\)Includes forceps and ventouse (vacuum) deliveries  
\(^3\)Includes breech and normal (non-assisted) deliveries

Note: Delivery methods are derived from the primary procedure code within a delivery episode.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts
As of January 2018, the trust had no active maternity outliers.
(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2017 MBRRACE audit, which is based on data for 2015. Their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 7 compared to 6.44 for the comparator group, indicating that performance was ‘worse than expected’.

When compared to other trusts with similar service provision, the trust’s rate was in the amber band indicating that it was up to 10% higher than the average for the comparator group.
(Source: MBRRACE UK)

The maternity unit were setting their own targets which were thought to be set too high and therefore why they were not achieving many of them. Staff told us they would like to use their regional dashboard as these targets were more reasonably set. However, we were told that no one had been allocated to lead on this project.

The service carried out a quarterly maternity early obstetric warning score (MEOWS). The audit for October to December 2017 highlighted that they were non-compliant with one of the standards as
one patient had did not have an action plan when scoring 3. An action plan has been devised to prevent further non-compliance.

The service also carried out audits such as compliance with birthing the baby by emergency caesarean section within the specified timeframes, induction of labour audit, which highlighted that 100% of women with Propess used as an induction agent had the requisite observations 4 hourly.

The service had reduced their stillbirth rate by 75%. Staff told us midwives were proud of achieving a reduction in the stillbirth rate by 75%. We were told that this was as a result of their work with the strategic clinical network around Each Baby Counts, which covered reduced fetal movements, “gap and grow”, and carbon monoxide screening in the antenatal period. We saw evidence of audits into this specific area such as the stillbirth audit, and identification of small for gestational age and/or fetal growth restriction in the antenatal period. The last two audits highlighted that they were achieving higher success rates than the regional and national in this area.

The obstetric team had been working with NHS Improvement as part of the GIRFT (Getting it Right First Time) initiative which is a Government funded initiative linked to NHS Improvement that is designed to improve clinical quality and efficiency by reducing unwarranted variations. We saw evidence the trust was notable for good practice in areas such as positive recommendations from the Friends and Family test, low third and fourth degree tear rate, low rates of emergency caesarean sections for multiparous women who laboured spontaneously and a high rate of vaginal birth after caesarean section.

We were informed that the induction rate had increased from 26% in December 2017 to 36%, largely as a result of the implementation of the ‘gap and grow’ (a programme to identify babies that are not growing adequately in the womb) initiative in the department. This initiative had led to access and flow issues. However, we were told that as a result of ‘gap and grow’ and working towards and with the national, regional and local initiatives to reduce stillbirth, the stillbirth rate in the department had reduced from 16 in 2016 to 4 in 2017. This was seen as a significant improvement.

**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 monitor the effectiveness of the service.

During our inspection we spoke to student midwives at different stages of their training who all stated that they were supported in their learning with mentors and other staff.

The trust used Practical Obstetric Multi-Professional Training (PROMPT) (a package that trains the attendees how to deal with obstetric and neonatal emergencies, primarily in a hospital situation) for maternity staff and of community PROMPT which was an adapted version for the home and birth centre scenario. We were informed that this latter training package was for ambulance personnel and community midwives to train together. We were informed that approximately 24 community midwives have completed this training to date.

There is a closed social media page that staff are encouraged to visit for learning and development.

There were no formal competencies for managing a labour and birth at home. However, the outpatient maternity manager and the practice development midwife were working on plans to address this.
We were informed that funding was secured for leadership training for maternity unit staff. All midwives had been asked to complete online cardiotocograph training by the end of June 2018. This was aimed at enhancing their competency in caring for both low and high risk women in labour and interpretation of the cardiotocograph printouts.

There was one band 7 midwife who was trained in high dependency unit care and, when working, supported inexperienced staff to care for women in high dependency unit.

Since the removal of midwifery supervision, the service had put in place measures to support and supervise midwives. Four midwives had been trained for the professional midwifery advocate role and two were doing so at the moment. The Trust were working within their Cheshire and Merseyside region to comply with NHS England recommendations.

Staff were positive about the introduction of the practice development lead who was very supportive to all maternity staff including student midwives.

Appraisals

Please note that we were unable to identify the number of medical staff members solely for maternity as the trust informed us that they employ obstetrics and gynaecology staff who cover both roles. Therefore the following analysis includes medical staff working in both maternity and gynaecology.

From April 2017 to October 2017, 41.8% of staff within maternity (and gynaecology for medical staff) at Arrowe Park Hospital had received an appraisal compared to the trust’s target of 88%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals completed</th>
<th>Eligible staff</th>
<th>Appraisal rate</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>30</td>
<td>64</td>
<td>46.9%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>35</td>
<td>82</td>
<td>42.7%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>16</td>
<td>46</td>
<td>34.8%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental staff (maternity and gynaecology) - Hospital</td>
<td>3</td>
<td>16</td>
<td>18.8%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Following the inspection, we were supplied with updated appraisal rate figures. Staff we spoke with also told us they had had an appraisal.

Appraisal compliance (March 2018)
Maternity medical staff 93.75%
Community midwives 100%
Hospital midwives 100%
Community support workers 100%
Hospital support workers 93.75%

Senior staff informed us that topical subjects were highlighted for extra focus such as human factors.

We were told that simulations of obstetric and neonatal emergencies were held to enhance training and monitor competence.

Approximately 24 midwives and 40 paramedics had attended obstetric emergency in the home birth setting training with the local NHS ambulance service. This training was not mandatory, but training devised following the identification of needs of midwives and paramedics.

Midwives we spoke with were positive about the six weeks given supernumerary for new starters, the improvements in learning and development since the new practice development midwife started and the closed social media page used to post information, incident feedback and learning and development.

We were told of suturing workshops facilitated by the department that had received positive feedback. They were voluntary for midwives and obstetricians whom wanted further training. This training was also open to maternity workers outside of the trust for a fee.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Midwives, obstetricians and other healthcare professionals supported each other to provide good care.

We were told, and observed, that there was good multi-disciplinary team work between the midwives and obstetricians.

We were told by a senior obstetrician that as well as the imminent planned opening of the “Pop up” birth centre, there were aims to open another one between their trust and a neighbouring one and that it was very well supported by the obstetricians.

There was effective internal multi-disciplinary working that included pharmacists, sonographers, theatre and housekeeping staff.

There was effective external team working with other trusts, social work departments, ambulance services, other NHS maternity providers and private maternity providers.

We observed collaborative working between the midwives employed by the Trust and private midwifery providers to provide joint working for the women and their families, for example showing a woman under private midwifery care around the unit in case she should need to be admitted at some point in her pregnancy.

**Seven-day services**

Maternity services were available seven days a week. Midwifery, obstetric and anaesthetic cover was provided outside of normal working hours and the midwifery staff we spoke to told us that they felt supported during these periods.

There was an antenatal clinic held within the trust where women could see obstetricians Monday to Friday.
There were antenatal clinics in the community across the geographical catchment area where women could access antenatal care with a midwife, Monday to Saturday.

Maternity triage area was open 24 hours a day, seven days a week and women were encouraged to telephone the dedicated number at any time if they had any concerns and following this they might be asked to attend for review if necessary.

Routine ultrasonography was available during working hours and urgent ultrasonography could be accessed outside these hours.

There was a consultant obstetrician presence on the maternity unit every day

Health promotion

At the booking appointment, all women were advised of the recommendation and importance to have the pertussis (whooping cough) and flu vaccinations (when applicable). They were advised to access this via their GP. However, they were also advised that if they could not, or choose not, to use their GPs, then they could access the “mums and midwives” drop in for these services.

At booking women were also given a plastic wallet which had been tailored for the specific needs of the women booked to birth at the trust which included information printed on the sides about reduced fetal movements, healthy eating in pregnancy and other health promotion subjects such as vaccinations recommended.

Community midwives had carbon monoxide monitors that they used to offer screening to all pregnant women at booking. Eligible women were then offered referral to the smoking cessation service.

We were informed that there were no barriers to skin to skin or delayed cord clamping being offered to all and we observed skin to skin being offered and facilitated following the birth of a baby by elective caesarean section. However, we also observed that leaflets were displayed in areas of the department advertising a private company offering stem cell banking and diagnostics. In order to obtain stem cells, blood has to be obtained from the umbilical cord following birth. However, if delayed cord clamping is facilitated for five minutes (NICE guidance recommends 1 to 5 minutes of delayed cord clamping) it is questionable whether sufficient cord blood would be obtained. We observed no information informing parents of this potential issue.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that their protecting vulnerable people courses contained modules relating to the Mental Capacity Act (MCA), Deprivation of Liberty safeguards (DoLS) and Mental Health Act training. Data on the individual modules within these courses was not provided.

The trust set a target of 95% for completion of protecting vulnerable people training.

The breakdown of protecting vulnerable people training completion from April 2017 to October 2017 for nursing staff in maternity at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 3</td>
<td>97</td>
<td>146</td>
<td>66.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 2</td>
<td>97</td>
<td>0</td>
<td>n/a</td>
<td>95%</td>
<td></td>
</tr>
</tbody>
</table>
The protecting vulnerable people courses contain modules relating to safeguarding adults, safeguarding children, PREVENT (training around the risks of radicalisation and the roles involved in supporting those at risk) Mental Capacity Act, Deprivation of Liberty Standards, domestic violence, Mental Health Act and dementia awareness.

Protecting vulnerable people level 3 training had been completed by 97 of the 146 nursing staff eligible for it (66.4%) in maternity while the trust indicated that no nursing staff were eligible for level 1 training. However, for level 2 training, they indicated that 97 staff members had completed the module although none were eligible. This suggests possible data quality issues.

We were unable to identify the number of medical staff members solely for maternity as the trust informed us that they employ obstetrics and gynaecology staff who cover both roles. Therefore the following analysis of training for medical staff includes staff working in both maternity and gynaecology.

The breakdown of training completion from April 2017 to October 2017 for medical staff in maternity and gynaecology at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained staff</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 2</td>
<td>13</td>
<td>3</td>
<td>433.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 3</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The protecting vulnerable people courses contain modules relating to safeguarding adults, safeguarding children, PREVENT (training around the risks of radicalisation and the roles involved in supporting those at risk) Mental Capacity Act, Deprivation of Liberty Standards, domestic violence, Mental Health Act and dementia awareness.

Protecting vulnerable people level 3 training had been completed by 11 of the 13 medical staff eligible for it (84.6%) in maternity and gynaecology while the trust indicated that no medical staff were eligible for level 1 training. However, for level 2 training, they indicated that 13 staff members had completed the module although only three were eligible. This suggests possible data quality issues.

(Source: Routine Provider Information Request (RPIR) P40 –Mandatory and Statutory Training)

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Where women with a history of mental illness were identified, there was a clear pathway for their care during and after pregnancy. There was a perinatal mental health guideline policy. There was a dedicated team who provided support ensuring women were signposted into the appropriate care service.

We examined two records and there was clear evidence of constant contact as well as multi-disciplinary meetings being attended by the patient. There were also clear warning signals within the patient’s electronic notes to alert other midwives when attending at the birth.

There was a central safeguarding team who identified and coordinated the trust response to mental capacity issues and Deprivation of Liberty Safeguards.
The pathway that had been developed was where it was identified that a patient potentially lacking capacity the trust computer system had a mandatory field for this assessment. Once capacity was assessed as an issue, the central team completed a formal assessment and applied to the local authority for a Deprivation of Liberty Safeguard.

We observed that consent for procedures was obtained, verbal and written where applicable, and documented prior to undertaking procedures.

**Is the service caring?**

**Compassionate care**

Friends and Family test performance

The trust’s antenatal friends and family test performance could not be assessed as the trust received too few responses.

From November 2016 to December 2017, the trust’s maternity Friends and Family Test (birth) performance (% recommended) was similar to the England average.

Friends and family test performance (birth), Wirral University Teaching Hospital NHS Foundation Trust

![Graph](image)

From October 2016 to October 2017, the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was also similar to the England average.

Friends and family test performance (postnatal ward), Wirral University Teaching Hospital NHS Foundation Trust
In October and November 2016 and April, June and October 2017, the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was similar to the average for England. In the remaining months, the trust’s performance could not be assessed as too few responses were received.

Friends and family test performance (postnatal community), Wirral University Teaching Hospital NHS Foundation Trust

(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of maternity services 2018

The trust performed better than other trusts for two out of the 15 questions in the CQC maternity survey 2017. For the other 13 questions the trust performed about the same as other trusts.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same</td>
<td>8.50</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>8.43</td>
</tr>
</tbody>
</table>
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? | About the same | 9.77 |
---|---|---|
Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth? | About the same | 9.22 |

| Staff during labour and birth |  |
| Did the staff treating and examining you introduce themselves? | Better | 9.73 |
| Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you? | About the same | 8.12 |
| If you raised a concern during labour and birth, did you feel that it was taken seriously? | About the same | 7.62 |
| Thinking about your care during labour and birth, were you spoken to in a way you could understand? | About the same | 9.61 |
| Thinking about your care during labour and birth, were you involved enough in decisions about your care? | About the same | 8.68 |
| Thinking about your care during labour and birth, were you treated with respect and dignity? | About the same | 9.45 |
| Did you have confidence and trust in the staff caring for you during your labour and birth? | About the same | 9.01 |

| Care in hospital after the birth |  |
| Looking back, do you feel that the length of your stay in hospital after the birth was appropriate? | About the same | 8.04 |
| Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed? | Better | 8.58 |
| Thinking about your stay in hospital, how clean was the hospital room or ward you were in? | About the same | 8.99 |
| Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? | About the same | 8.79 |

(Source: CQC Survey of Women’s Experiences of Maternity Services 2018)

Staff cared for women and their families with compassion. Feedback and observations confirmed that staff treated them well, with kindness and compassion.

Women described care from midwifery and obstetric staff as good or excellent.

All staff introduced themselves and communicated well to ensure women fully understood.

Women were encouraged to ask questions and were given time to ensure they understood what was being said to them.
We observed staff involving women and those close to them in decisions about their care and treatment.

Women were encouraged to provide feedback about the service in a variety of ways.

In theatre, we observed staff protecting a woman’s dignity during a caesarean section.

During observations of the handover on the ward area we saw this was carried out at each of the midwives’ stations which could easily lead to a breach of confidentiality as many of the rooms were within hearing distance. As well as discussions of midwifery and obstetric issues, safeguarding cases were discussed. When asked, the two midwives being observed said that if there was someone about they would go somewhere more confidential.

**Emotional support**

Staff provided emotional support to women and their partners to minimise their distress.

We observed staff providing reassurance and comfort to women as required by women.

In one edition of the “maternity services news brief” it was highlighted that all midwives were reminded to ask women if they required a debrief prior to discharge and to facilitate this prior to discharge if feasible or to arrange a follow up appointment if it was felt to be a more complex discussion.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment. We observed staff interacting positively with women and those close to them.

Staff spoke to women and their families sensitively and appropriately, dependent on individual need. Staff respected women’s choices and delivered their care with an individualised person-centred approach.

Women and their families told us that they received relevant information in a manner which they understood. Partners were encouraged to attend with the women for antenatal care.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided services to meet the needs and wishes of its service users. Services were provided to reflect the needs of the local population such as specialist clinics and a pop-up antenatal clinic in a local shopping centre.

The service had a mums and babies drop in service facilitated by the trust’s community midwives from a shop premises in a local shopping centre. It was open from 10am until 3pm Tuesday through to Saturday and women did not need an appointment. They could attend without an appointment for any antenatal care, the aforementioned vaccinations or advice.

**Bed Occupancy**
From quarter 1 of 2016/17 to quarter 2 of 2017/18 (April 2016 to September 2017) the bed occupancy levels for maternity fluctuated.

The rates were higher than the England average in 2016/17 quarter 1 and 2 before dropping to a similar level for two quarters. However, in 2017/18 quarters 1 and 2 they increased once more to be higher than the proportion for England.

The chart below shows the occupancy levels compared to the England average over the period:

![Graph showing occupancy levels compared to England average]

(Source: NHS England)

**Meeting people’s individual needs**

The service took account of people’s individual needs. The service provided additional support and services to women such as pregnant teenagers, women with mental health needs and women who did not speak English as a first language.

On the postnatal ward, we observed that the midwives referred women and their families in need of support to a local charitable organisation that worked with the maternity unit to provide practicable support to families in the area and whom also provided breastfeeding support in the community. The unit also referred mothers to the frenulotomy clinic where they assess and, if necessary cut, the excess piece of skin under a baby’s tongue which can restrict breastfeeding and also speech later in life. This clinic was run by the breastfeeding specialist midwife.

We observed feeding support to new mothers who were artificially feeding their baby, which included sterilisation, baby led feeding and positioning.
Antenatal care for pregnant teenagers was provided by a community midwife and supported by the midwife for teenage pregnancy who carried out a risk assessment for all pregnant teenagers booked to receive their care at the trust and co-ordinated extra support where deemed necessary. All pregnant teenagers were invited for their antenatal scans on a Wednesday and the teenage pregnancy midwife could meet with them to provide support and advice. The teenage pregnancy midwife told us she tailored her service to meet the needs of the women by, for example, providing parent craft sessions on a one to one basis to prepare the young mothers and their partners, for parenthood.

Women with mental health issues were cared for by their named midwife and supported by the named midwife for mental health.

The service had a bereavement specialist midwife to provide support to women who had lost their babies. It was building a purpose built bereavement suite which was funded by a stillbirth charity.

The service was temporarily using one of the labour ward rooms until this work was completed.

The service had a range of clinics to meet the needs of the women. The service had a vaginal birth following caesarean section clinic that gave relevant information to women so they were able to make an informed choice about their birth. The breech clinic for women whose babies were bottom down as opposed to head down informed women of their options such as elective caesarean section or external cephalic version (where a trained practitioner would attempt to rotate the baby to the correct presentation whilst still in utero). The birth choices clinic gave information for women who may, for example, be anxious about birthing their baby vaginally and wish to opt for an elective caesarean section instead.

Aromatherapy was available to women and was facilitated by one of the 17 midwives trained in this practice.

The service had a team of five “high risk midwives” whom have received training to carry out ultrasound scans for pregnant women. We were informed that the team was set up following an issue of scanning capacity within the scanning department. Therefore this team of midwives were established and trained, some to carry only third trimester scans and some the full complement of pregnancy scanning and fetal medicine.

There was a system in place to contact an interpreting service for women whose first language was not English and the staff we spoke to were aware how to access this.

There were two midwives who covered all aspects of the elective caesarean section lists, from clerking in, pre-operative checks, attending the birth and the immediate postnatal period in recovery. This ensured continuity of carer throughout this period at what may be an anxious time for parents.

The service had a maternity services liaison committee where women who use or used the service could give feedback and help influence future maternity service provision at this unit. The service also had a “maternity focus group” that met every third month with 16 women currently involved in this group.

All women booked to receive their care from the maternity department were provided with access to a mobile phone application, from an external organisation, that provided a variety of information regarding pregnancy.

The department had numerous leaflets on display around the unit that women and their families are encouraged to take and read such as breastfeeding and pain relief in labour. There is further information regarding pregnancy and birth provision on the departments web page that women are
encouraged to access during their pregnancy. However, displayed on the wall inside the out of hours entrance to the maternity unit there was a very large display board highlighting the role of midwifery supervision and with a contact number displayed that women could call and speak to a supervisor of midwives 24 hours a day, seven days a week should they wish to discuss any aspects of their pregnancy care or their choices. However, midwifery supervision, certainly the model promoted on the board, ceased approximately one year before. Whilst there were plans to replace this with PMAs, there is nothing currently. Therefore the poster and the contact details are misinforming women and their families. This was escalated this to a senior member of the maternity team and she stated that she would address this issue.

Since our inspection we observed on the Trusts maternity webpage that it also highlights supervision of midwifery in much the same way.

The service had a newborn hearing screening team which screened babies hearing prior to discharge from the hospital or in a follow up clinic, for babies birthed at home.

We observed a “welcome” sign inside the entrance to the labour ward in 12 different languages.

Mental health support was available from a dedicated mental health specialist midwife who supported midwives in caring for the women.

**Access and flow**

Whilst women could access the service when they needed it, there were times when the care for women requiring additional support was delayed.

The named midwife for each woman is responsible for ensuring that women who do not access care as recommended are followed up and an appropriate plan is put in place in applicable.

Within the year before the inspection the unit only had to close for new admissions once, for five hours, and divert women to another hospital. We were given evidence of the subsequent investigation into what happened and why. This highlighted the cause of staffing and high acuity.

At times during our inspection the transitional care area was not open to admissions due to lack of adequate staffing skill mix, for example, one day there was no maternity assistant practitioner rostered to work so they could not accept patients. On the inspection we saw that this had caused delays for women waiting to be induced and waiting to move from the neonatal intensive care area.

**Learning from complaints and concerns**

**Summary of complaints**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From November 2016 to November 2017, there were 17 complaints about maternity. The trust took 61.6 days to investigate and close these complaints.

The trust has not provided details of the level of the complaints. Their complaints policy states that level 2 complaints should be closed within 25 days; level 3 complaints within 45 days; and complex level 4 complaints in 60 days.
The themes from the 17 complaints were:

- Communication – 10 complaints
- Standard of care – five complaints
- Prescribing – two complaints

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Complaints were investigated by the inpatient matron. She said that, where applicable, she disseminated to the staff via patient stories and at the daily huddles. We were informed of a change in practice that was initiated following an influx of complaints about late medication administration. The practice of women now self-medicating on the wards was initiated to avoid such delays and subsequent complaints.

The service carried out an audit into complaints.

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Is the service well-led?

**Leadership**

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

There were clearly defined and, for the most part, visible leadership roles across the maternity service.

The head of midwifery was supported by dedicated maternity matrons and band 7 lead midwives.

The head of midwifery and other senior midwives told us they were contactable at any time day or night to provide support to the team since the removal of statutory supervision of midwives on call and that there was an open door policy. The head of midwifery told us there were plans to formalise the manager on call system for senior midwives.

Some midwives felt that the senior management team were not as visible as they would like them to be.

Most midwives felt that the band 7 leaders were very supportive.

Staff told us that the trust’s executive team were not visible in the unit.

We were told by some clinical area midwifery managers that the new Head of Midwifery was “Proactive, Approachable, Visible (when around) and Open to new ideas” such as “K2”, which is an online perinatal training programme, and the proposed “induction of labour suite.” Also, that the new management team “Has balanced everything”

**Vision and strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
The department had a clear vision and strategy “to provide safe, high quality, cost effective midwifery and obstetric care benchmarked against national standards, best practice and sound governance arrangements for service users across the Wirral and surrounding areas.”

Furthermore, the head of midwifery articulated a clear vision and strategy of the type of midwifery service that her and her team were striving for. This was to provide an excellent high standard of care, engage with the national five year forward plan for maternity services to improve maternity care provision for the future and work with neighbouring trusts to achieve this.

They are an early adopter site for implementation of NHS England’s vision for maternity care in the future that, amongst other recommendations, gives women more choice about where they birth their baby, which has been the main driver for their pop up birth centre. They have also developed joint pathways with alternative, non NHS, midwifery providers to further facilitate women’s choices.

At the time of our inspection the trust were finalising plans to open a pop up birth centre in a children’s centre within their catchment area. This was as part of their regional work working towards the vision set out in the Better Births document which highlighted the five year forward view for maternity services. It is called a pop up birth centre because it is opened in an area where it is believed to be most wanted by women, but that can be moved and placed somewhere else if women’s choices dictate.

Following an incident and subsequent investigation with delayed transfer to the labour ward of a woman undergoing induction of labour, there are plans to open a dedicated induction of labour suite for low risk women on the labour ward instead of on the ward as it is currently situated.

We were told about plans to develop a safeguarding vulnerable women’s midwifery team to facilitate both specialised care for the women and their families and to better support the generic community midwives.

Senior staff told us that the work with the local Sustainable and Transformation Programme, a Government initiative to streamline NHS services to make them viable for the future, had allowed their department more autonomy to move the service forward.

The hope is to achieve the funding to recruit more infant feeding specialists to support breastfeeding mothers on the unit 24 hours per day, seven days per week.

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. All staff were positive about the improvements to the culture since the last inspection.

Staff we spoke to felt that the culture within the unit was good and, for those that had worked here for some time, they told us it was much improved in the last 18 months.

Maternity staff told us that they felt they were understaffed and, although not unsafe, due to changes in the community model, this had affected continuity of carer for the women and the midwives’ job satisfaction. They said they did not attend meetings that influence decision making because they were too busy.

The head of midwifery told us that there had been a focus on improving culture in the last two years. She felt that much of this was addressed by bringing in a new senior team, creating new roles in the department such as a consultant midwife and a new management structure.

Staff told us it was a good place to work and that the culture of the unit was now good, especially since the department became was separated from the surgery department as the management team were now more focussed on their department and the department had its own identity.
Senior staff told us that historically the trust’s freedom to speak up guardian had several contacts regarding the department but that it was markedly lower now.

Staff voiced that they have “they have safety guardians now.”

**Governance**

There was currently no governance lead midwife in the department. However, there was an interim divisional lead in post who was managed by the operational divisional director. They facilitates meetings such as the quality improvement meetings, care importance form meetings and the quarterly governance meetings. Discussed at these meetings were incidents, risks and 72 hour reviews.

We saw evidence of the proposed trust wide governance structure. However, we were also shown evidence of correspondence from the leads in the maternity unit to the Trust board questioning the rationale behind this proposed new structure and arguing for a separate governance lead and structure specifically for maternity. At the time of writing this report we were told they had not yet received a response.

Senior medical staff informed us that patient safety issues were identified through audits, observation and staff and patient feedback so that timely and appropriate action could be taken to ensure a patient-centred, high quality, safe maternity care service.

There was no dedicated governance lead midwife. Governance responsibilities were included within some senior midwives managerial roles. Escalation was to the head of midwifery, who worked closely with the interim divisional governance lead, who was new in post and was employed on a short term contract only.

Senior midwives (with governance roles) told us that they did not have protected time within their role for governance and that they sometimes found it difficult to juggle their governance, managerial and clinical duties. We were informed that they felt like “they were filling a gap” and a lot of their time spent on governance was completed in extra hours and out of “good will”.

Senior medical staff informed us that the current governance structure had improved within the last year. However, they told us there was much to do in this area and that a permanent member of staff with sufficient dedicated time for governance, was needed.

We observed a “Huddle Board” as part of the handover from night staff to day staff. Subjects shared included promotion of completion of the Friends and Family Test, an update on which equipment needed replacing on the neonatal resuscitaires, Ensuring that the time and date of the start of labour is recorded on the partogram, that the neonatal intensive care unit and the transitional care units were currently closed and five high risk women that were inpatients in the unit but not on the labour ward.

**Management of risk, issues and performance**

While the service had systems for identifying risks, planning to eliminate or reduce them. Some identified risks such as women undergoing induction of labour in side rooms on the ward or unqualified midwives recovering women following emergency caesarean sections were not on the risk register.

The service had a maternity risk register that highlighted four risks across the maternity service. These were as follows

1. The paper postnatal notes and a potential breach of patient confidentiality.
2. The potential closure of labour ward rooms due to faulty beds.
3. The lack of baby tagging.
4. Potential areas of non-compliance with NICE guidance CG190.

Risks were identified in a variety of ways, for example following a reported incident or recognition of a theme or trend. The incidents were discussed at the weekly care meetings and escalated to the interim governance lead and head of midwifery to be added to the risk register if appropriate.

We were informed that the ongoing risk regarding midwives having to recover women following an out of hours caesarean section would be added to this list. These meetings were attended by senior staff in the department and we were informed that the risk register was reviewed regularly.

High risk inductions of labour were carried out on the labour ward.

**Information management**

The maternity service did not have a current robust data collection system, such as a maternity dashboard. While the service collected information it was not presented so it could be easily used to benchmark outcomes, review clinical and quality performance and implement clinical changes.

The service collects data to populate their dashboard with monthly figures such as the normal birth rate, third and fourth degree tear rates and staff training. However, the dashboard we were supplied with upon request had several omissions of these figures. We were informed that this was due to staff sickness and vacancies.

Staff told us that the trust executive board had not been “forthcoming” with developing the maternity dashboard.

The service undertook local and national audits and used the outcome data to review clinical outcomes, resources, safety and areas of improvement. Monitoring performance and improving practice was also benchmarked against other local and national trusts and feedback from initiatives such as the “Get it right first time” (GIRFT) programme which helps to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes.

The maternity service did not have a current robust data collection system, such as a maternity dashboard. While the service collected information, it was not presented so it could be easily used to benchmark outcomes, review clinical and quality performance and implement clinical changes.

Senior staff acknowledged the lack of a dashboard to effectively collect and correlate patient outcomes and were waiting on the implementation of a regional dashboard which they would implement. Senior medical staff told us that the current dashboard was “unacceptable” and was due to a lack of ownership and management of the dashboard.

The service had an electronic board in the labour ward office that had details not only of the women admitted to triage but also other clinical areas such as the midwifery led unit and triage, therefore facilitating an overview of other clinical areas in the unit.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The service had a maternity services liaison committee, where women who use or had used this service could give feedback and help influence future maternity service provision. Furthermore,
the service also had a “maternity focus group” that met every third month with 16 women currently involved in this group.

The service received feedback from patients using “learning with patients maternity services”. This was a feedback form that women were asked to complete and post back to the trust in a pre-paid envelope about differing aspects of the care they received.

“Listening into action” sessions were held to make improvements for staff and patients and that the trust’s values arose from these sessions.

Staff were invited to regular meetings pertinent to their area of work. One example of this is the community midwives who are invited to regular meetings that, amongst other areas of discussion, keep staff up to date with the opening of the new pop up birth centre.

The unit had signed up to the Royal College of Midwives “Caring for You” campaign which was an initiative set up by the midwifery union to promote maternity departments to care for and look after their staff.

The service had a maternity services liaison committee where women who use or used the service could give feedback and help influence future maternity service provision at this unit. The service also had a “maternity focus group” that met every third month with 16 women currently involved in this group.

The service had a “star of the month” award whereby staff and patients were able to nominate a member of staff.

The service had a “Do it” box where staff were able to post anonymous feedback and ideas or resolutions that was then reviewed at the sister’s meetings.

We saw evidence in the fortnightly maternity publication where staff were invited to attend free sessions/training in such areas as mindfulness and “your mind set, your choice masterclass”

Highlighted within this publication was news of the STAR of the month which staff can nominate colleagues for god work and there is one award for delivery suite and one for the ward. Within these publications are details of new vacancies within the department, staff moving to new roles, new starters, and personal touches such as wishing a staff member well as she starts her maternity leave and congratulations to a member of staff on their recent wedding.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

The maternity department were runners up in this year’s Royal College of Midwives excellence in midwifery education, learning and research award for its multidisciplinary training course for paramedics and community midwives. The nomination was in recognition of the service addressing feedback about the lack of training for the home environment and too few updates on obstetric emergencies.

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care could flourish. However, the dashboards we were shown that highlights rates and trends of specific issues such as third and fourth degree tears (classifications of perineal tears) was incomplete in several cases. We were informed that this was due to “staff illness and lack of ownership”.

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The Outpatient Manager informed us that she acknowledges there are many changes in the community teams and to this end she facilitates monthly meetings that all community midwives are invited to attend to keep them abreast of the changes. Furthermore, she has “Do It” boxes where staff can post concerns, queries and suggestions.

The interim divisional governance lead had made changes to the response to incidents. She had instigated joint reviews for incidents, such as one including the ambulance and neonatal staff. She had strengthened the 72 hour review process which now promoted a quick fix. For example, a recent review about a missing suturing needle went before the panel and it was agreed that a root cause analysis was not needed. However, there was an immediate change in practice regarding the introduction of a suture pack, thus improving safety for patients and staff.
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.

End of life care

Facts and data about this service

The trust provides end of life care at their Arrowe Park Hospital site. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, palliative and end of life care, and bereavement support and mortuary services.

The trust had 1,565 deaths from October 2016 to September 2017.

(Source: Hospital Episode Statistics)

The trust is part of the North West Coast Palliative and End of Life Strategic Clinical Network. Their team of consultants in palliative medicine collaborate with integrated specialist palliative care nurses to help patients on the end of life pathway and their families cope with their condition and treatment of it.

(Source: Routine Provider Information Request (RPIR) – Context Acute)

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

Overall mandatory training rates

This information is routinely requested within the universal provider information request
spreadsheets, to be completed within a standard template.

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

Block A contains manual handling, health and safety level one, risk management level one, consent awareness, end of life care and moving and handling modules. Block B contains fire safety, infection prevention and control and medicines management modules.

Information provided by the trust following inspection showed that between August and December, 2017 100% staff working in palliative and end of life care had completed mandatory training blocks A and B.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The mandatory training system had recently changed, and was now accessed through the electronic staff record system. Some additional elements had been added in recent months which could only be accessed via the electronic staff record and it had taken some time for all consultants to obtain passwords and arrange remote access.

Mandatory training was reviewed regularly at the consultants meeting, and also discussed and reviewed within annual appraisal.

Changes had been made to the way mandatory training, including end of life care, was delivered within the organisation which meant that it was now more tailored to the individual groups of staff. For end of life care this meant that block A was for end of life care specialists, for example the clinical nurse specialists, block B was for staff who had regular contact with end of life care patients and block C was for staff who seldom had contact with patients at the end of life.

The end of life care facilitators delivered a mandatory half day training course to all care support workers as part of their core skills care certificate training. This focused on care and compassion and their role in care of the dying. It included training on mouth care from the oral hygienists and guidance on care after death (last offices) based on the Royal Marsden manual. By March 2018 this had been completed by 92 staff.

All qualified nurses new to the trust completed mandatory syringe driver training. Refresher training was available as and when required, and the end of life care facilitators provided one to one training if it was requested.

Safeguarding

Safeguarding training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust reported that their protecting vulnerable people courses contain safeguarding adults and children modules. Data on the individual modules within these courses was not provided.

The trust set a target of 95% for completion of protecting vulnerable people training.

The breakdown of protecting vulnerable people training completion for nursing staff in end of life
care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting vulnerable people Level 2</td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The protecting vulnerable people courses contain modules relating to safeguarding adults, safeguarding children, PREVENT, Mental Capacity Act, Deprivation of Liberty Standards, domestic violence, Mental Health Act and dementia awareness. Information provided by the trust following inspection showed that protecting vulnerable people level 2 training had been completed by 100% of staff providing specialist palliative and end of life care. Level 3 training had been completed by 83% of staff providing specialist palliative and end of life care.

The protecting vulnerable people courses contain modules relating to safeguarding adults, safeguarding children, PREVENT, Mental Capacity Act, Deprivation of Liberty Standards, domestic violence, Mental Health Act and dementia awareness.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

There was a safeguarding team in the hospital and staff we spoke with knew how to contact them. Ward staff told us they generally made referrals on the electronic system, then telephoned the team to alert them that the referral had been made.

If a safeguarding concern arose out of hours staff could contact the matron on call, the hospital coordinator or the duty manager. Hospital coordinators were band 7 nurses who worked at weekends and from 8pm to 8am on week nights, supporting the managers and matrons.

When a safeguarding alert had been raised for a patient, a flag showed on the electronic system and remained even after the safeguarding record had been closed.

Cleanliness, infection control and hygiene

Body bags were available for deceased patients who may present an infection control risk and were in regular use.

The mortuary included a visibly clean and tidy waiting area and viewing room.

Environment and equipment
Syringe drivers were serviced annually and we saw an up to date asset log which was held in the electro-biomedical engineering department. This included service dates and the location of the syringe drivers.

**Assessing and responding to patient risk**

We reviewed ten records for patients receiving end of life care and all had documented medical reviews at least daily, usually a consultant in palliative medicine, and daily reviews by the palliative care team.

We attended a daily multidisciplinary team meeting and saw good discussion of risk management and a comprehensive hand over for all the patients under the care of the palliative and end of life team.

There was a psychiatric liaison team who provided a service to the hospital. The team were employed by the local mental health trust, but accepted referrals from the acute hospital and were on site regularly. This team could be called upon if staff were concerned about risks associated with a patient’s mental health.

**Nurse staffing**

**Overall staffing rates**

The trust reported the following nurse staffing numbers for end of life care at Arrowe Park Hospital in March and October 2017. The service was slightly over-establishment in both periods.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Actual WTE Staff in post</th>
<th>Planned WTE Staff in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>2.2</td>
<td>2.0</td>
</tr>
<tr>
<td>October 2017</td>
<td>2.2</td>
<td>2.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The following nurse staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The two end of life care facilitator posts were delivered by three nursing staff within the corporate nursing structure. These were a band 7 lead nurse (0.6 whole time equivalent), and two part time band 6 end of life care facilitators. The band 7 lead nurse spent a further one day per week (0.2 whole time equivalent) in the role of learning disability nurse.

For specialist end of life or palliative clinical care, referrals were always passed to the clinical nurse specialists or consultants in palliative medicine. The clinical nurse specialists who provided palliative and end of life nursing care in the hospital were employed by the local community trust and commissioned to provide a service to the hospital trust.

**Vacancy rates**

From November 2016 to October 2017, Arrowe Park Hospital reported a vacancy rate for nursing staff in end of life care of -10.6%, indicating that the service was over-established. The trust does not have a target vacancy rate.
Turnover rates

From November 2016 to October 2017, Arrowe Park Hospital reported no turnover for nursing staff in end of life care. The trust target is to have less than 10% turnover.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Sickness rates

From November 2016 to October 2017, Arrowe Park Hospital reported a sickness rate for nursing staff in end of life care of 4.8% which was higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

From November 2016 to October 2017, Arrowe Park Hospital reported no bank or agency usage for nursing staff in end of life care.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

There was a 5.5 whole time equivalent palliative medicine consultant resource in total across Wirral, and all team members collaborated to provide a 24-hour advice line to hospital and community settings.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Actual WTE Staff in post</th>
<th>Planned WTE staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2018</td>
<td>2.1</td>
<td>2.2</td>
</tr>
</tbody>
</table>

At the time of our last inspection in September, 2015, there were two part time consultants in palliative medicine who worked at the hospital, which represented 0.7 whole time equivalent posts. This was below the recommended staffing level for a hospital of this size and was reviewed by the organisation following the inspection.

The recommendations for specialised level palliative care (Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives, December 2012) describe the minimum workforce to support working week services per 250-bed hospital as one full time equivalent consultant/associate specialist in palliative medicine, dependent on the type of hospital provision and specialist services provided.

Arrowe Park Hospital had 848 inpatient beds at the time of our inspection, however they had calculated their establishment figure for consultant in palliative medicine cover as 2.5 whole time equivalent. This took into consideration the structure of the service including input from the clinical nurse specialists employed by the community trust and medical staff from the hospice.

At the time of our inspection there were 2.1 whole time equivalent due to one person recently leaving and the service had just lost four clinical sessions due to a vacancy. The service was in the process of appointing a GP with a special interest in palliative and end of life care and the consultants in palliative medicine told us this would mean there was adequate medical cover.
The consultant who was also the clinical service lead for palliative and end of life care was based at the hospital full time and was also part of the on call rota for the local hospice which was in place 24 hours a day, seven days a week. A second full time consultant in palliative medicine was also based at the hospital but one day per week (0.8 sessions) was office based. The third consultant in palliative medicine was based mostly at the hospice but delivered two clinical sessions at the hospital which allowed them to build relationships with patients who were likely to be transferred to the hospice later.

The hospital had recently started to participate in registrar training which meant that middle grade doctors based at the hospice for training in palliative medicine spent 50% of their time at the hospice and 50% at the hospital.

Vacancy rates

From November 2016 to October 2017, Arrowe Park Hospital reported a vacancy rate for medical staff in end of life care of -18.5%, indicating that the service was over-established. The trust does not have a target vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From November 2016 to October 2017, Arrowe Park Hospital reported no turnover for medical staff in end of life care. The trust target is to have less than 10% turnover.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From November 2016 to October 2017, Arrowe Park Hospital reported no sickness absence for medical staff in end of life care. The trust target is 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

From November 2016 to October 2017, Arrowe Park Hospital reported no bank or locum usage for medical staff in end of life care.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Records

Most of the patient information was stored on an electronic patient record system. Some records were still recorded on paper, for example daily weight charts, medicine reconciliation forms, electrocardiogram results and do not attempt cardiopulmonary resuscitation forms.

The end of life care record was recorded on paper at the time of our inspection but was due to be moved onto the electronic system in the coming weeks. At the time of our inspection there was no flag on the electronic patient record to indicate that a patient was coming towards the end of their life. This was communicated by verbal handover and the paper record of care.
We reviewed 10 records for patients receiving end of life care. All had the name and grade of doctors and nursing staff clearly documented and all had details regarding ceiling of care recorded. There was clear evidence of discussion with family on all records.

Six had clear palliative care plans or a Record and Prompt for Adult Care in the Last Days of Life document in place to support their care, and one was due to be commenced on this. Five had preferred place of care documented, but none had advance care plans in place.

Discharge summaries were sent to GPs when patients receiving end of life care were discharged, and these included a copy of the consultant’s opinion taken from the electronic patient record. However, palliative care information was not always included as the patient received a copy of this letter so it was not always appropriate.

Where a patient was undergoing a rapid discharge and needed a GP visit, a consultant for palliative medicine would telephone them to request this. Close links with the palliative and end of life team meant that patients being discharged from the hospital were usually already known to the community team and there were plans for a GP with a special interest in palliative and end of life care to join the service, which would further foster links with GPs.

The documentation on the electronic patient record was only recorded chronologically and was not searchable. This meant that if a member of staff wanted to find a particular document, they needed to know approximately when it had been written. This made some documentation hard to find.

**Medicines**

We reviewed ten prescription records for patients receiving end of life care; these were a mix of paper and electronic records.

All had end of life care medication, including anticipatory medication, appropriately prescribed and documented. All had daily medication reviews documented and writing was legible. Those on syringe drivers had the appropriate checklists in place and completed regularly and clearly.

There had been eight medication or prescribing incidents and one poor symptom control incident reported between 1 April 2017 and 30 September 2017 in relation to end of life care.

Following investigation of these incidents, electronic syringe driver prescribing had been identified by the service as a priority to support safe prescribing. At the time of our inspection syringe driver prescribing was still on paper records, which had resulted in errors whereby an oral long-acting opioid and opioid via continuous subcutaneous infusion were prescribed concurrently.

All syringe drivers were the recommended type and were stored in the electro-biomedical engineering department.

**Incidents**

**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 January to December 2017, there were no incidents at the trust that were classified as never events within end of life care.
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, two serious incidents (SIs) occurred in end of life care at the trust which met the reporting criteria set by NHS England from January to December 2017.

Both of the incidents occurred in the mortuary: one incident involved a faulty refrigerator/alarm system which led to the deterioration of a patient’s body and the other involved a post-mortem on the wrong patient.

There was an electronic incident reporting system and staff knew how to use it. A process was in place for the governance team to filter all incidents containing words related to palliative and end of life care and forward them to the end of life care managers so they could be reviewed at the weekly business meeting.

This meant that although incidents were reported in the clinical area and division where they occurred, the palliative and end of life care teams had oversight of those related to their service. This enabled any necessary immediate action to be taken, and relevant learning could be disseminated in advance of the full investigation process. The palliative and end of life care team could also provide support where necessary, to individual ward teams involved in investigating an incident.

The weekly business meeting was attended by a quartet compromising the clinical service lead for palliative and end of life medicine, the lead for the palliative and end of life team, the divisional business manager of palliative and end of life care, and the end of life care lead nurse.

There were 55 reported incidents relating to end of life care between 1 April 2017 and 30 September 2017. These were summarised in a six monthly end of life patient experience and safety report presented to the palliative and end of life care team meeting at the end of November 2017.

There was evidence of lessons learned from incidents, for example a high proportion of incidents had been noted to have been reported by the acute medical unit when compared with other ward areas. This was felt to be related to the rapid turnover of patients in this unit as the majority of patients who were subsequently admitted to medical wards passed through this setting. Additional palliative medicine consultant resource had been targeted to the acute medical unit since June 2017, with a daily clinical session allocated there from Monday to Friday. This had resulted in a fall in the number of incidents reported from that unit in relation to end of life care.

There was a weekly safety summit which was open to all staff. It was chaired by the interim director of governance and was an opportunity for staff to present learning following investigation of incidents.

Is the service effective?

Evidence-based care and treatment
The service used a Wirral multidisciplinary Record and Prompt for Adult Care in the Last Days of Life document for patients receiving end of life care. This was referred to as the record of care, and had been developed by a Wirral wide working group which included representation from the hospital, hospice and community.

The record of care was designed to incorporate the five priorities of care for the dying person from One Chance to Get it Right (Leadership Alliance for the Care of Dying People, June 2014). Each of the five priorities were set out, with prompts for staff to complete details underneath of how the priorities were being met.

Recognised symptoms that can occur at the end of life were set out in a daily template with actions taken recorded next to them. There were also sections for a daily medical review and nutrition and hydration status.

The percentage of patients receiving end of life care who were supported by the record of care was recorded on the monthly palliative and end of life care dashboard. Between April 2017 and December 2017 the record of care was used in 75 (40%) of 186 cases.

We reviewed in detail, three Record and Prompt for Adult Care in the Last Days of Life documents. These were completed appropriately with good records of symptom management, spiritual care, discussions with family, personal care and mouth care.

The palliative and end of life care service had undertaken a gap analysis to assess their compliance with the NICE (National Institute for Health and Clinical Excellence) End of life care for adults quality standard (QS13, 2011).

Quality statement 7 requires that families and carers of people approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences. The service had identified this as a gap and there was an action to address it as part of service re-design plans.

**Nutrition and hydration**

We reviewed 10 patient records and all had assessments of hydration status and fluid balance charts where appropriate. Eight of the 10 records had assessments of nutritional status completed.

**Pain relief**

We reviewed 10 records for patients receiving end of life care and saw good evidence of pain management.

We spoke with 16 patients who were receiving palliative or end of life care and those who mentioned pain relief were positive about it and said that nurses responded quickly to pain issues.

There was a pain scale in use for assessment of pain in patients who cannot verbalise, for example patients living with dementia or communication difficulties. However, although staff referred to this and told us they had used it, they were unable to locate examples of it on electronic patient records.

This was because all the documentation was filed in the same place and there was not a separate location for assessments or different plans of care.

Symptom control relief guidelines including pain management were available for staff to access on the trust intranet.
Patient outcomes

End of life care Audit: Dying in Hospital

The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed better than the England average for two of the three agreed clinical indicators:

- Metric 2: Proportion of patients for whom there was documented evidence within the last episode of care that health professional recognition that the patient would probably die in the coming hours or days (imminent death) had been discussed with a nominated person(s) important to the patient (excluding sudden/unexpected deaths and there was recognition as likely to die) – 95.2% at the trust compared to a national aggregate of 95%

- Metric 3: Proportion of patients for whom there was documented evidence in the last 24 hours of life of a holistic assessment of the patient’s needs regarding an individual plan of care (excluding sudden/unexpected deaths and restricted to patients with a length of stay >24 hours) – 94.0% at the trust compared to a national aggregate of 73%

However, the trust had a slightly lower proportion of patients for whom there was documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days (excluding sudden/unexpected deaths) (metric 1) – 87.5% at the trust compared to 93.4% nationally.

(Source: Royal College of Physicians)

The trust achieved all off the national organisational audit indicators.

Since the 2016 national audit, the trust’s Adult Palliative and End of Life Care Strategy (2016-2019) had been agreed and was part way through implementation. This incorporated service developments aimed at improving all areas of care identified in the audit as requiring improvement.

In April 2017 the service completed an audit of Record and Prompt for Adult Care in the Last Days of Life. They reviewed 30 cases where patients had been commenced on the record of care, and 29 that were not. The objectives were to assess whether individualised care in the last days of life was delivered in line with the Priorities of Care for the Dying Person (Leadership Alliance for the Care of Dying People, June 2014) and NICE Guidance for Care of dying adults in the last days of life (National Institute for Health and Care Excellence, December 2015).

The results of the audit showed that patients who had a record of care in place had better documentation in place around their end of life care, and had also received better care than those who had died without a record of care. It also demonstrated overall improvements for care of patients who were dying, when compared with the last audit in 2015.

In the 2017 audit, in relation to the recognition that the patient was entering the dying phase, there was evidence of multidisciplinary decision making in 51% (30/59) of cases which was an improvement from the 2015 audit where only 10% (3/30) had evidence of this. Evidence of multidisciplinary decision making was 67% (20/30) in cases where the record of care was used compared to only 31% (9/29) where the record of care was not used.

Where it was possible, 53% (28/53) of patients had their preferred place of death documented compared to 23% in 2015. Of these, 79% (22/28) had a record of care in place.
Actions from the audit included the introduction of the record of care in electronic form. This had been delayed but was ready at the time of our inspection and was due to be launched in the coming weeks.

We saw evidence that other local audits were taking place in end of life care. These included an audit of compliance with Wirral palliative care symptom control guidelines audit in November 2017, and a baseline review of end of life care in haemodialysis patients in January 2018. Both audits had reports, recommendations and action plans in place.

The palliative and end of life care had participated in a regional care of the dying evaluation led by NHS Improvement which had conducted a site visit in January 2018. Findings by NHS Improvement were largely positive about the service.

The trust had also sent a multidisciplinary delegation to visit another local hospital trust to share best practice and take any learning back.

**Competent staff**

Developing further end of life care training opportunities for all staff formed part of the Adult Palliative and End of Life Care Strategy 2016-2019. Work on this had begun, but was not complete.

The end of life care facilitators provided education to ward staff, primarily supporting them to support the families of patients who were coming towards the end of life. This was delivered on an ad hoc basis as and when required.

They also delivered an end of life care study day eight times per year. This was open to all nursing staff and allied health professionals. Numbers attending were relatively low at the time of our inspection, partially due to a lack of capacity for staff to be released from the ward to attend the training. To date, in March 2018, 41 staff had completed this training.

Care in the last days of life was delivered to junior doctors as part of the foundation year one teaching programme and 72 doctors had received this by March 2018. Training on managing palliative care emergencies had been completed by 30 foundation year two doctors.

There was a monthly end of life care development programme available which included syringe driver training and this had been completed by 93 staff.

An e-learning “end of life care for all” programme was available for all staff but this was not yet fully embedded.

Lack of communication skills training for all staff was identified as a risk on the risk register. Actions proposed to address this included the lead end of life care nurse and one of the consultants in palliative medicine exploring the feasibility of a Wirral locality wide collaborative communication skills training model. This would be delivered by appropriately skilled facilitators from Wirral healthcare organisations and would be accessible by healthcare staff from within participating organisations, including the trust.

The Amber care bundle is used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff,
patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the patient not improve.

Supported by the NHS Emergency Care Improvement Programme and the National Council for Palliative Care a consultant in the acute medical unit had conducted a small test of change using the first two stages of the Amber care bundle with 10 patients. This test was extended to a further 16 patients in elderly medicine.

The trial of the Amber care bundle went well and there were plans to extend it further. These were set out in the palliative and end of life care team action plan. The next stage was due to take place between April 2018 and June 2018 when the bundle was due to be introduced and embedded on a medical ward.

A working group for the Amber care bundle had been set up and their first meeting was due to take place in March 2018. Five staff had attended a national study day.

There were seven volunteers supporting end of life care at the hospital and they received support from the end of life care facilitators, including training and monthly group supervision. The volunteers completed a five week education programme before commencing their duties. This included communication skills, some mouth care, and awareness of boundaries as volunteers.

Every new member of staff received a 15 minute introduction to end of life care when they attended the trust’s induction programme. This included information on providing care and compassion at the end of life and promoting the vision that this is “everybody’s business” regardless of whereabouts in the hospital staff worked.

The end of life care facilitators had monthly group supervision as a team.

There were end of life link nurses and care support workers on some, but not all, of the wards and they attended monthly end of life care meetings. Further development of this role was identified as an objective in the Adult Palliative and End of Life Care Strategy 2016-19.

Appraisal rates

Information provided after our inspection showed that in December, 2017 89% of staff within end of life care at Arrowe Park Hospital had received an appraisal compared to a trust target of 88%.

Multidisciplinary working

The three end of life care facilitators were experienced nurses who worked predominantly in an educational, facilitating role. They were not clinical nurse specialists but provided more generic information and support around end of life care.

The facilitators and palliative and end of life team were working collaboratively where possible, however the clinical nurse specialists in the palliative care team were employed by a different trust and had different line management arrangements which could sometimes lead to miscommunication between the teams.
We observed a daily multidisciplinary board round attended by the consultants in palliative medicine, the end of life care facilitators and the clinical nurse specialists. Staff from other disciplines also attended where appropriate, for example oncology and community staff.

At the board round there was good multidisciplinary working. Staff discussed “what matters most today” for all the patients listed on the board which were those under the care of the palliative and end of life team. There was a comprehensive handover of all patients and discussion included symptom management and any issues likely to arise over the next 24 hours.

It was clear who was going to see which patient that day and there was evidence of support for team members whose caseload may be heavy.

An electronic alert (digital time assessment) was delivered to the end of life care facilitators when an end of life record of care had been commenced for a patient. A facilitator would then visit the relevant ward to offer support and guidance to the staff, patient and family as required.

The integrated discharge team worked with staff from social care, community and the hospital to facilitate complex discharges for patients receiving palliative or end of life care.

There were plans for working more closely with the critical care outreach team as sometimes both teams were seeing the same patients. The critical care outreach team was involved with the plans to implement the Amber care bundle.

**Seven-day services**

The end of life care facilitators provided a service between Monday and Friday, 8.30am to 4.30pm. They worked in collaboration with the palliative and end of life care team which provided a seven day service with a minimum of three clinical nurse specialists in the hospital Monday to Friday, and two at weekends.

There was a 5.5 whole time equivalent palliative medicine consultant resource in total across Wirral, and all of these doctors collaborated to provide a 24-hour advice line to both hospital and community settings. The trust’s clinical staff could contact the patient advice and liaison line either directly or via switch board from 5pm to 9am, 365 days a year. The consultants in palliative medicine were not on-site within the hospital during these hours.

**Health promotion**

There was an end of life care folder on every ward with information leaflets for families including practical advice such as how to access the parking concession passes.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust reported that their protecting vulnerable people courses contain modules relating to the Mental Capacity Act (MCA), Deprivation of Liberty safeguards (DoLS) and Mental Health Act training. Data on the individual modules within these courses was not provided.
The trust set a target of 95% for completion of protecting vulnerable people training.

From April to October 2017, protecting vulnerable people training had been completed by 61.5% of all staff within end of life care.

The breakdown of PVP training completion for nursing staff at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting vulnerable people Level 2</td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The protecting vulnerable people courses contain modules relating to safeguarding adults, safeguarding children, PREVENT, Mental Capacity Act, Deprivation of Liberty Standards, domestic violence, Mental Health Act and dementia awareness.

Protecting vulnerable people level 2 training had been completed by one of the three nursing staff eligible for it. The trust indicated that no nursing staff had completed or were eligible for the level 1 and 3 modules.

The breakdown of protecting vulnerable people training completion for medical staff at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Trained (YTD)</th>
<th>Eligible (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Target met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVP Level 3</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PVP Level 2</td>
<td>3</td>
<td>0</td>
<td>n/a</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The protecting vulnerable people courses contain modules relating to safeguarding adults, safeguarding children, PREVENT, Mental Capacity Act, Deprivation of Liberty Standards, domestic violence, Mental Health Act and dementia awareness.

Protecting vulnerable people level 3 training had been completed by three of the six medical staff eligible for it. The trust indicated that no medical staff were eligible for level 1 training. However, for level 2 training, they indicated that three staff members had completed the module although none were eligible. This suggests possible data quality issues.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff we spoke with on the wards said that band 2 staff and above had more awareness of the Mental Capacity Act and safeguarding concerns since the organisation had introduced the new mandatory training course called protecting vulnerable people.

A unified version of the do not attempt cardiopulmonary resuscitation (DNACPR) forms was in use which meant that it was in paper format and travelled with the patient. There was a unified DNACPR policy in place which applied to all multidisciplinary healthcare teams involved in patients’ care across the range of settings within the hospital and community NHS trusts.

There was a target of 75% compliance for documented evidence of discussion about the DNACPR with the patient or relatives. The palliative and end of life care dashboard showed that between January 2017 and December 2017 this was exceeded every month except in October 2017 when compliance was 71%. In November 2017, 30 patients were audited and a compliance of 94% was achieved. In December 2017, 30 patients were also audited and 90% compliance was achieved.
Do not attempt cardiopulmonary resuscitation documents were stored on the wards in secure trolleys. We reviewed ten DNACPR forms. Of these, four indicated that the patient lacked capacity but no mental capacity assessments could be found on file. One of the assessments had been undertaken in the community, but the other three forms could not be found. It was not possible to ascertain whether the assessments had been undertaken but could not be located, or whether they had never been completed. This was because of the way documents were filed on the electronic patient record system.

Is the service caring?

Compassionate care

There was an emphasis in the service of providing care and compassion to patients receiving end of life care, and their relatives.

We spoke with 16 patients receiving palliative or end of life care and nine relatives.

Questionnaires about the care their loved one received in the hospital and input from the bereavement team after death were given to every bereaved family when they collected the patient’s medical certificate of cause of death. Between February 2017 and January 2018 results from this questionnaire showed that 201 (88%) of 228 respondents were likely or extremely likely to recommend the trust.

A butterfly symbol was used in the ward areas, for example on the side room door or curtains around the bed, to indicate a person was coming towards the end of their life. The intention was that this would serve as a reminder to people to be especially sensitive. A lily was used on after care documentation, following a person’s death.

There were fold up beds available for relatives to stay in a side room on the ward with the patient if they chose to. When patients were not in a side room relatives could use the fold up beds in a quiet room or day room on the ward.

Family members were encouraged to be as involved as they wanted to be following a relative’s death. They could travel to the mortuary with their relative if they chose to, although ward staff we spoke with said this rarely happened.

Porters and ward staff were respectful of patients’ and families’ privacy and dignity. Porters could lock the lifts to put them temporarily out of use if there were distressed family members accompanying their relative to the mortuary. Trolleys carrying the deceased were discretely covered with heavy blue fabric and there was nothing to indicate they were transporting a body.

The bereavement team supplied ‘ties for treasures’ which were small, handmade bags for storing personal effects such as jewellery from the person who had died.

The work done as part of the Emergency Care Improvement Programme and the National Council for Palliative Care included some environmental improvements for visitors to the mortuary. There was an appropriate waiting area in the mortuary complete with information leaflets about local bereavement services. There was a viewing room where families could visit their loved ones after death. Further improvement work was planned.

Emotional support
The bereavement team offered support to relatives in the immediate aftermath of a family member’s death. As well as providing emotional support they helped with practical tasks if required, for example providing information on how to inform all the government organisations of a relative’s death in one notification.

Information leaflets about what to expect when someone important to you is dying and when a patient is seriously ill were available for families. Each ward had an end of life care box with a butterfly symbol containing this information.

A bereavement pack including a comprehensive booklet detailing practical help for bereaved people was offered to the family when they collected the medical certification of the cause of death.

The bereavement team sent out condolence cards to bereaved families approximately two weeks after death. The card included the team’s telephone number and families were invited to call for advice or support if they needed it.

There was a pro-active chaplaincy and spiritual care team who were available 24 hours a day, seven days a week. The team focused more on spirituality than religion and were managed by a very visible and enthusiastic head of the chaplaincy department who had extensive knowledge and experience around death and dying.

This team had close links with religious leaders in the community and took a multi-cultural approach. Their aim was to reflect and support people in their own faith and this was reflected in the chapel which had different areas for different beliefs, including an atheist area for non-believers.

**Understanding and involvement of patients and those close to them**

Patients we spoke with were positive about the service. One said they were a partner in their care rather than being told what was happening and decisions were shared, rather than imposed. Patients said they had been consulted about their wishes for future care and plans were being put in place to accommodate these.

New information leaflets about planning for your future care had been produced for patients. These included examples of the types of wishes and preferences people may choose to express in advance, and information about advance decisions to refuse certain types of treatment.

It had been agreed at the Wirral clinical commissioning group palliative and end of life partnership meetings that the North West coast strategic clinical network approach to advance care planning would be adopted Wirral-wide.

At the time of our inspection there was no specific advance care plan documentation in place, however patients’ wishes were being discussed and documented. The silver and bed gold days project meant that what was important to patients receiving end of life care was discussed at every daily board meeting.

A patient held advanced care planning framework and an electronic template had been developed. The advance care plan included space to record what was important to the patient at the time and in the future, what their wishes and preferences were, and what their concerns and fears were.

It also included the person’s preferred place of care, details about a lasting power of attorney and an advanced decision to refuse treatment. This advance care planning documentation was due to come into use in 2018 and this was detailed on the palliative and end of life care quarterly action plan for 2018-19. It was also linked in with the planning for the Amber care bundle.
A task and finish group was planned to look at the roll-out of the new approach across Wirral. Within the trust, initial tests of change would be started within specialist palliative care and for renal patients.

There was good knowledge in the service about who to approach for information about organ donation. There was a clinical lead and a specialist nurse for organ donation based in critical care where there was also a prominent information board on display in the entrance area. Information for staff, patients and families included the organ donation team details, organ transplant information line and information on how to join the organ donor register.

### Is the service responsive?

#### Service delivery to meet the needs of local people

Facilities and premises were appropriate for the services being delivered. There was a clean and newly furnished family room in the bereavement office where relatives could meet with the bereavement team to collect the medical certificate of the cause of death and receive support about other processes, for example registering the death.

The bereavement team could also make appointments for the relatives to visit their family member in the mortuary. In the mortuary the viewing area for bereaved families had recently been improved. There were plans for further improvement work to be undertaken.

There was a current adult death administration policy and procedure in place which set out the time frame in which a medical certificate of the cause of death should be issued. The policy stated that the doctor must complete the certification process on the ward “as soon as possible and before they finish their shift”.

Certificates were required to be with the bereavement office by 12 noon for all deaths before 8am and deaths between 8am and 12 noon should have certificates completed and with bereavement services by 4pm. Certificates for deaths occurring after 12 noon should be with bereavement services by 12 noon the next working day.

The bereavement team collected data to monitor this process. Between January 2017 and December 2017 (inclusive) there was an average of 67% compliance with the timescales. The monthly data collected by the bereavement team was sent to the deputy medical director who shared it with all consultants. It was also recorded on the palliative and end of life care dashboard and reviewed in the monthly palliative and end of life care steering group meetings, as well as at the trust wide clinical governance meetings.

There were various proposals to continue trying to address this problem which was also identified as an issue by the service at the time of our last inspection in September 2015. One of the consultants in palliative medicine had agreed to conduct a walk through with doctors to see where the delays were occurring. An escalation policy had been suggested so that if a doctor was busy there was a clear direction as to who could be contacted next.

The palliative and end of life care steering group minutes from the 1 March 2018 indicated this issue was due to be included on the trust-wide risk register. We did not see evidence of this at the time of the inspection.

In the evening and at weekends the clinical coordinators could organise for a medical certificate of the cause of death to be issued very quickly if necessary to comply with religious or cultural practices.
There was a team of seven volunteers supporting the end of life care service at the hospital. The volunteers provided companionship to patients and families if they wished, and acted as a conduit for information.

We spoke with a member of the bereavement team who had received training on matters related to organ donation and this was ongoing. They also knew the process for those patients who wished to donate their body to the university.

**Meeting people’s individual needs**

Staff we spoke with were aware of different religious and cultural practices following the death of a family member or close friend. They also knew how to access a hospice website which included a comprehensive guide on beliefs, key issues, eating, food and drink, and death and dying for 40 different religions. They provided a recent example of when they had moved a patient’s bed around to enable them to sleep facing east as they wished.

Translator facilities were available to the service. Staff knew to contact the switchboard or an out of hours coordinator to organise provision of an interpreter.

The service had access to a psychiatric liaison team who were employed by the local mental health trust. The team accepted referrals from the trust and were on site regularly. This team could be called upon if staff felt a patient needed a mental health assessment.

One of the end of life care facilitators worked one day per week as a learning disability liaison nurse across the trust. They were able to provide several positive examples of how this role had impacted on patients at the end of life, and their families. The nurse was knowledgeable about the Learning Disabilities Mortality Review (LeDeR) programme and was clearly providing a good service, although it was limited by time constraints.

There was a reasonable adjustment care plan for patients with cognitive impairment or learning disabilities. This was completed in conjunction with carers and families and included information about what the patient liked and disliked. There was a similar ‘this is me’ document for patients living with dementia, that noted their personal preferences. Both of these documents could be printed from the trust intranet.

There was a project underway to improve patient flow through the hospital, called “safer”. This was part of the Emergency Care Improvement Programme (NHS Improvement) that the trust had participated in. The safer project included a ‘red to green bed days initiative’, where red was a day with no value to the patient and green was a day of value to the patient.

The palliative and end of life care service worked in collaboration with the Emergency Care Improvement Programme and the National Council for Palliative Care and adapted the patient flow ‘red to green’ days for end of life care patients. They re-named the initiative ‘silver to gold’ to distinguish it from the red to green project and it targeted patient experience rather than patient flow.

In the daily board every morning the palliative and end of life care service discussed what patients said they most wanted to make things better – “what mattered most” to them. At 4pm the team discussed whether this had happened or not. If the patient’s wish had been achieved, the day was categorised as a gold day. It if had not happened, they still had an hour to escalate the request and make it happen. If the task was not achieved, the day remained as a silver day.

The aim was to achieve gold days where possible, but analysis of silver days provided learning in terms of understanding the barriers to patients achieving their wishes for end of life care. Initial
findings identified availability of packages of care to support discharge and availability of hospice beds were the most common blockages to patients achieving their preferred place of care.

Sometimes matters such as symptom control could not be resolved within one day. The multidisciplinary team said they had gathered a lot of patient centred data about what patients actually wanted, not what the service thought the patients wanted.

This information had been presented to the service commissioners in November 2017. There was a partnership meeting with commissioners every two months, attended by the GP commissioning lead, clinical commissioning group lead and senior representatives from the hospital, hospice and community across the geographical area. The palliative and end of life care service leads were hoping to present the silver and gold bed day outcomes regularly, with a view to it informing the commissioning decisions.

Ward staff told us they always tried to facilitate a side room for a patient at the end of life if this is what they wanted, and it was usually achieved. Occasionally it was not possible because patients presenting with an infection control risk took priority.

**Access and flow**

A consultant in palliative medicine attended a daily clinical session in the acute medical unit. Since starting this, incidents related to end of life care for patients admitted to the acute medical unit had reduced and the consultants felt they better met patients’ needs when they were involved earlier in their care.

Referrals to the palliative and end of life care teams were often made via the consultant’s attendance on the acute medical unit. Electronic referrals could also be made to the clinical nurse specialists, and these generated a secure email to the team based in the community.

There were no ‘time based’ targets for referrals to be met by the palliative and end of life care service at the time of our inspection. The consultants told us that hospital key performance indicators were clinical needs based, rather than time based. The default position was to try and have a dialogue with the referrer.

The community nurse specialists kept their own records within the community trust regarding timely response to referrals. They provided evidence to us which showed that where data was available, they exceeded their 98% target for all their key performance indicators between April 2017 and February 2018. These included the percentage of patients receiving a 24 hour response, percentage of patients seen within two working days and within four working days based on clinical need. The data we reviewed was corroborated by staff on the wards who told us they always received a timely response from the clinical nurse specialists.

There was a rapid discharge process, with involvement from an integrated discharge team and the district nurses where appropriate. There was also a fast track discharge process which had different criteria.

If a rapid discharge had been requested this generally referred to a patient in the last few hours or days of life. We spoke with three members of the integrated discharge team who said that everyone “pulled out all the stops” for a rapid discharge and they usually managed about two per month. This reflected information recorded on the palliative and end of life care performance dashboard.
When they received a request for a rapid discharge the integrated discharge team went as soon as possible to the ward to talk with the family and explain the process. They arranged the ambulance, checked the correct medications were prescribed and spoke directly to the district nurses. They ordered any necessary equipment which was usually delivered well within the four hour target. They also explained what would happen if the patient died in the ambulance; when this happened, the patient could still be transferred home.

A fast track discharge was a similar process but needed social packages of care to be in place before the patient could go home. The local ‘hospice at home’ service could support with night sits and the integrated discharge team could arrange this with them.

Rapid and fast track discharges were recorded on the palliative and end of life care team’s monthly dashboard. Between January 2017 and December 2017 (inclusive) there had been between zero and seven rapid discharges per month with a total of 28 for the whole year. The average number of hours from referral to discharge was 31 hours.

During the same period there had been between eight and 26 fast track discharges per month, with 200 in total for 2017. The average number of days from referral to fast track discharge was six days.

**Learning from complaints and concerns**

**Summary of complaints**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From November 2016 to November 2017 there was one complaint about end of life care. The trust took 42 days to investigate and close this complaint.

The trust has not provided details of the level of this complaint. Their complaints policy states that level 2 complaints should be closed within 25 days; level 3 complaints within 45 days; and complex level 4 complaints in 60 days.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Between January 2017 and December 2017 the palliative and end of life care dashboard recorded ten complaints in relation to patients who were receiving end of life care. However, the complaints were not specifically about the palliative and end of life care team.

All complaints relating to end of life care, and subsequent responses, were reviewed by the clinical service lead for palliative medicine and discussed at the weekly business meeting when relevant.

Communication was identified as the most complained-about issue within end of life care and communication skills training had been identified as a priority area of need. The lack of communication skills training available within the hospital had been entered on the risk register.

**Is the service well-led?**

**Leadership**
The clinical lead for palliative and end of life care was a consultant in palliative medicine. There was also a band 7 lead nurse managing the end of life care facilitators and volunteers, and a service manager for the community based palliative care team.

We spoke with all of the managers and leads for the teams and found them all to be enthusiastic, experienced, and knowledgeable about their service. They were visible and approachable, and were working together to move the service forward.

The director of nursing was the executive lead for end of life care and the clinical lead for palliative and end of life care said they had good access to them. A new non-executive director for end of life care had recently been appointed.

There was a palliative and end of life care steering group which met monthly and had oversight of the strategy and action plan. The trust wide clinical governance group received six-monthly updates on the progress made by the palliative and end of life care steering group to deliver the strategy.

**Vision and strategy**

The service had a comprehensive strategy (Adult Palliative and End of Life Care Strategy 2016-19) which it was implementing. The strategy included the six ambitions as set out in the national framework for local action 2015-2020 (National Palliative and End of Life Care Partnership) which were underpinned by five high impact enablers.

Progress to date included an increase in consultant in palliative medicine funding from 0.7 to 2.5 whole time equivalent and the paper record of care had been introduced with an electronic version due to be rolled out imminently. This was one of the enablers related to the priorities of care (One Chance to Get it Right).

Work on the other enablers was beginning, with a trust working party meeting scheduled for the week of our inspection, to discuss plans to implement the Amber care bundle. The implementation of the strategy had been delayed by some changes to the trust executive team but the local leadership were very clear on their direction and endeavouring to maintain the momentum.

The service had an ambition to make palliative and end of life care as good as it could possibly be each and every time. There was a hospital palliative and end of life care redesign plan developed in January 2018 which set out an operational plan for meeting their vision to provide care that was proactive, well-coordinated and patient focused.

This included a proposal to unite the different elements of the current palliative and end of life care provision into one cohesive team reporting to the same management and divisional structure. The plan defined the performance measures they would use up to 2020 and listed the current service improvement projects underway, for example the silver to gold bed days and daily in-reach into the acute medical unit.

Developing the multidisciplinary base within the palliative and end of life care team was part of the strategy and the service redesign plan. The plan was to develop more integrated relationships with other specialties and expand the core team to include representation from chaplaincy, therapy services, a discharge coordinator and medical social worker resource.

There was a proposed quarterly palliative and end of life care action plan from 1 April 2018 to 31 March 2019. This set out a high level schedule for the rollout of the electronic record of care for patients in the last hours or days of life, the Amber care bundle and Advance care planning. It also included objectives for better use of the palliative and end of life team activity data and to review...
capacity and demand for the service. This action plan was due to be agreed at the palliative and end of life care team meeting at the end of March 2018.

Culture

There were three end of life care facilitators including the lead nurse within the corporate nursing structure which was a different division to the consultants in palliative medicine who were within the medicine division.

The clinical nurse specialists who provided end of life nursing care in the hospital were employed by the local community trust and commissioned to provide a service to the hospital trust. They provided a seven day service with a minimum of three specialists nurses in the hospital Monday to Friday, and two at weekends.

This meant that the three different disciplines providing palliative and end of life care within the hospital were reporting to different line managers and staff said that they did not always fully engaged with each other. We saw evidence that the teams were trying to work together and support each other.

Staff said there were times when there were competing priorities. For example, clinical nurse specialist capacity provided by the community trust had been variable and inconsistent at times. Staff had rotated between the community and the hospital and staff said it had been challenging to build relationships as there was no memorandum of understanding describing the service and no honorary contracts.

This meant that some information held by the community trust had not been readily available to the consultants in palliative medicine employed by the hospital trust. This included activity data and the electronic lists of patients receiving end of life care from the palliative and end of life care team. These problems were being addressed and worked through, but staff told us it had been challenging at times, for all concerned.

However, all the staff we spoke with passionate about their roles in palliative and end of life care. The mortuary technician spoke about improvements to practice following two recent incidents; the bereavement team lead had won a ‘Proud Award’ in September 2017 and the religious and spiritual care team were enthusiastic and pro-active in their roles. The bereavement team went on to win the national ‘Unsung Hero: The Team of The Year Award’ in February 2018.

Ward staff said the palliative and end of life team was visible and approachable and the end of life care facilitators were providing support and training to different levels of staff, including the volunteers. The consultants in palliative medicine had a clear vision of the direction of the service and were working to achieve this.

The volunteers we spoke with, who had also won a ‘Proud award’ said they were well supported by the end of life care facilitators who made them feel valued and valid members of the team.

Staff we spoke with in all of the different teams knew what duty of candour was, and gave examples of being honest and transparent with the families they dealt with.

Governance

There was a weekly business meeting for end of life care, attended by a quartet comprising the clinical service lead for palliative and end of life care, the lead for the palliative and end of life care team, the divisional business manager of palliative and end of life care, and the end of life care
lead nurse. The meeting was the first step in the governance process, where they reviewed all incidents and complaints, as well as the six monthly patient experience report.

As this meeting was weekly it enabled the quartet to act quickly when problems arose. For example, they could go to the clinical area to visit the patient if they were still in hospital. Recently they had received two complaints in quick succession in one particular area, so had booked in refresher training to address the issues raised.

There was a monthly palliative and end of life care steering group with an agenda which routinely included reviewing and discussion around the performance dashboard and an update from the bereavement team.

There was a clinical governance group which received six-monthly updates on the progress made by the palliative and end of life care steering group, to deliver the palliative and end of life care strategy.

The model of delivery advocated by the North West Palliative and End of Life Care Operational Group used a whole systems approach for all adults with a life limiting disease, regardless of age and setting, moving from recognition of need for end of life care, to care after death. This model was used to define which incidents were reviewed by the palliative and end of life care team which enabled them to include incidents related to anyone in the last year of life, anyone who might die and after death care.

The palliative and end of life care performance dashboard was reviewed at the monthly palliative and end of life team meeting. This was chaired by the clinical lead for palliative and end of life care and attended by the non-executive director for end of life care and representatives from the different divisions.

Management of risk, issues and performance

Service leads were clear on where there were risks in palliative and end of life care and they were reviewed at the monthly clinical governance group and locally, at the monthly steering group and the weekly business meetings where necessary.

The risks associated with palliative and end of life care were recorded on the corporate risk register. These included a gap in access to communication skills training for staff of all grades and disciplines within the hospital and a failure to meet all of the recommendations in the NICE Guidance for Care of dying adults in the last days of life (National Institute for Health and Care Excellence, December 2015).

There were controls and actions in place to mitigate the risks identified. The service re-design document included some of the details to address the NICE guidance, for example there were plans to implement the outcome assessment and complexity collaborative measures which are designed to improve palliative care services provided to patients and their families.

The trust provided us with three risk register documents. One included trust-wide risks with seven related to palliative and end of life care, some of which had not been updated since 2017. Three of these were corporate risks, two were identified as medical and acute specialties, one was from the surgery, women’s and children’s division and the final risk was from the laboratory medicine division.

The second document was the corporate risk register and listed one risk, which was also included on the trust-wide risk register.
The third risk register was for medical and acute specialties and listed three risks, two of which were also included on the trust-wide register. One of these three risks had controls related to a different risk recorded next to it.

It was noted in the palliative and end of life care steering group minutes from 1 March 2018 that concerns around controls and mix up of outstanding actions on the risk register had been raised by the clinical service lead with the relevant team but the problem had not been resolved. There were also some issues around members of the team accessing the risk registers in the different divisions. These concerns had been escalated to the quality governance team.

Descriptions of quality improvement initiatives (including responsibilities and timescales) were set out in the strategy action plan. These included an end of life care training needs analysis and training strategy for all staff, as well as developments within the bereavement service.

We spoke with one of the anatomical pathology technicians in the mortuary who was aware of the business continuity plan should an environmental issue cause a disruption to mortuary services. This included access to 18 further spaces in a mortuary at the Clatterbridge hospital site.

**Information management**

There were some problems locating information on the electronic patient record. A large amount of the documentation relating to a patient was stored in an electronic folder on the record, but staff we spoke with did not know how to search for it.

This meant that when they wanted to try and find a particular document, for example a mental capacity assessment or a pain scale assessment, the only way to do so was to scroll through all the documents which were filed in chronological order. This was time consuming and not always effective. We spoke with several different staff who had been unable to find documentation they needed.

If a staff member did not know when the document they needed had been completed, a search could involve sorting through dozens of documents over several months. These could include documents from several different specialties.

Another challenge with the information management system was that the different end of life care teams used different electronic records. This meant that some information had to be duplicated onto two different systems, the community electronic record, and the hospital electronic record. This was time consuming for the staff involved which included the consultants in palliative medicine when patients were known to both teams.

However, the Wirral medical interoperability gateway (GP patient information) and health information exchange (Wirral University Teaching Hospital patient information) project securely connected the two computer systems together. When patient records were requested by the consultants in palliative medicine, it collected the information from the different systems and showed the information to the requestor. None of the information was stored and none of it could be changed. Because it collected the information only when it was needed, the information was always as up to date as possible.

There was a virtual white board on the electronic system. This comprised a list of patients receiving end of life care, with check boxes next to their names to indicate when they had been seen by a consultant in palliative medicine and when they were due to be next seen. Referrals
could be accepted this way, and the caseload could be accessed from home when the consultants were on call. They could click on the patient’s name and go straight to their electronic record.

**Engagement**

There was good engagement between the palliative and end of life care staff and patients using the service.

Since July 2016, all bereaved families of patients who had died at the trust were given a paper-based bereavement questionnaire when they collected the medical certificate for cause of death. A stamped-addressed envelope was also provided.

Responses received from the questionnaires were recorded on a spreadsheet, including individual comments from families. Results were collated and added to the monthly performance dashboard and the six monthly patient experience report.

Themes were identified and correlated with complaints and incidents. Lessons learned were discussed at the weekly business meeting and actions were tracked on an action plan.

A patient story from either the hospital or the community trust was included in the monthly palliative and end of life care steering group agenda.

**Learning, continuous improvement and innovation**

There were a number of different projects being undertaken within the Wirral local digital roadmap footprint which was based on the Healthy Wirral initiative. Proactively engaging with opportunities presented by Healthy Wirral and the health information exchange was an objective set out in the palliative and end of life care strategy.

One of the aims of the project was to bring together health and care information from the disparate electronic records across the Wirral health and social care economy to create a single record. The single record would enable Wirral partners to define and create wellness and disease registries to assist in standardising pathways of care.

The registries were designed to enable front line staff to know in real time from the registry “measures” if the person they were looking after was getting “the right care”. It would enable clinicians to see the whole patient record not just part. Seven of the eight registries were already in development and it had been agreed by the clinical commissioning group that the eighth registry would be developed for palliative and end of life care.

Electronic patient care co-ordination systems were identified as one of the high impact enablers in the Adult Palliative and End of Life Care Strategy 2016-19 but the registry would supersede the need to implement an electronic palliative care co-ordination system (EPaCC) as it would perform the same functions and more. For example, it would enable the recording and sharing of people’s care preferences and key details about their care at the end of life. Prognostic indicators would flag for end of life care patients, and GPs would have access to the records.