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 hospitals at the trust is below. This inspection is focussed on the main Countess of Chester Hospital site.

<table>
<thead>
<tr>
<th>Name of hospital site</th>
<th>Address</th>
<th>Details of any services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countess of Chester Hospital</td>
<td>Liverpool Road, Chester, Cheshire CH2 1UL</td>
<td>Full range of medical services including acute and emergency care, breast screening, cancer services and maternity services. A full list of services offered is available on the trust website.</td>
<td>Western Cheshire, Ellesmere Port, Neston and North Wales.</td>
</tr>
</tbody>
</table>
| Ellesmere Port Hospital        | 114 Whitby Road, Ellesmere Port CH65 6SG     | Rehabilitation/intermediate care and outpatient clinics for the following:  
  - Physiotherapy  
  - Radiology - including X-ray and Ultrasound  
  - Mental Health  
Consultant clinics including:  
  - Rheumatology  
  - Podiatry  
  - Audiology  
  - Orthopaedics  
  - Neuro-Physiotherapy  
  - GP Out of Hours Service                      |                                                                                                              |

(Source: Trust Website)

The Countess of Chester Hospital NHS Foundation Trust consists of a large district General Hospital which has 600 beds, which provides its services on the Countess of Chester Health Park and an Intermediate Care Service which has 64 beds at Ellesmere Port Hospital.

The Trust has approximately 54,798 staff and provides a range of medical services to more than 445,000 patients per year from an area covering Western Cheshire, Ellesmere Port, Neston and North Wales.

The Countess of Chester Hospital provides a full range of acute and a number of specialist services including urgent and emergency care, general and specialist medicine, general and specialist vascular surgery and a full consultant led obstetric and paediatric hospital service for women, children and babies. In Ellesmere Port Hospital the trust provides medical care services, rehabilitation and intermediate care to patients over 65 years age. It has 64 beds over three wards.

The trust saw over 66,000 inpatient admissions between June 2017 and May 2018. There were also over 640,000 outpatient attendances and over 84,550 accident and emergency attendances in the same period. There were 2,649 babies delivered and 1,128 patient deaths at the trust during this period.
We carried out a comprehensive inspection at the trust in February 2016. We rated responsive as requires improvement. Safe, effective, caring and well-led were rated as good. We rated the trust as good overall and issued requirement notices in regard to Regulation 12: Safe care and treatment; Regulation 13: Safeguarding; Regulation 17: Good governance and Regulation 18: Staffing. The trust put action plans in place, which have been monitored by CQC.
Is this organisation well-led?

Leadership

The trust had a board which consisted of executive directors and non-executive directors. The trust board had the appropriate range of skills, knowledge and experience to perform its role. The board was made up of the following members:

- Chair
- Chief executive [Interim]
- Director of nursing and quality (also the acting deputy chief executive)
- Director of people and operational development
- Chief operating officer
- Chief finance officer
- Acting medical director [Interim]
- Director of corporate and legal services (non-voting member)
- Five non-executive directors

The trust had undergone a period of instability within the executive team. There had been changes to the executive team since our previous in February 2016, which included the appointment of an interim Chief Executive Officer (CEO) in September 2018 and a new interim Medical Director in October 2018.

The trust executive leadership team had an appropriate range of skills, knowledge, experience and commitment. The performance of the executive leadership team was reviewed and monitored through an annual appraisal process to ensure that they maintained the skills, knowledge and integrity to carry out their roles. There was also an annual appraisal review process for the non-executive directors.

We noted that not all of the executive team portfolios were balanced to ensure they had capacity to deliver their responsibilities. For example, the director of nursing had a large portfolio that included overall responsibility for nursing and safeguarding as well as being the Senior Information and Risk Owner. The director of nursing also had oversight of risk management across the trust and was the executive with responsibility for the board assurance framework. The director of nursing told us that the previous chief executive officer had appointed the board assurance framework oversight because the leadership team was in a period of flux. The director of nursing acknowledged that having responsibility for the board assurance framework and nurse staffing meant there could be conflicts when addressing quality issues and nurse staffing concerns.

Executive directors were supported by deputy directors with specific responsibilities, aligned to their portfolios, to support them in their roles.

Leaders understood the challenges to quality and sustainability faced by the organisation. The executive team were all able to articulate the financial, performance and quality challenges to the trust in the short, medium and long term. Board members all understood that the integration of health and social care services as essential to the sustainability of the trust and clearly articulated the trust’s role in the changes to the health and social care economy.
The trust met 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. We looked at executive and non-executive director employment files, which were completed in line with the FPPR regulations.

Directors and non-executive Directors undertook a programme of walkabouts and reported these back at board meetings. However, some staff across the service told us that they felt senior leaders were not visible or approachable.

The trust reported processes were in place for leadership development and succession planning across the senior and divisional management levels. There was a development day held for all members of the board in 2018 and in addition an externally facilitated development away day was held in November 2018. There were also eight board workshops scheduled to take place during 2019, with the first being a facilitated workshop on risk appetite.

There was a succession plan and talent management exercise planned to take place in January 2019 to inform future nominations for leadership programmes such as the trust’s internal ‘Aspirational Talent’ programme. The programme included a top down review of senior teams facilitated by using a recognised career management tool known as the ‘nine box’ grid.

**Board Members**

Of the executive board members at the trust, 0% were Black and Minority Ethnic (BME) and 66.7% were female.

Of the non-executive board members 0% were BME and 50% 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>53.8%</td>
</tr>
</tbody>
</table>

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

The trust vision was ‘to deliver NHS care locally that makes our staff and our community proud by being Safe, Kind and Effective’.

The trust vision and values were developed taking into account the views and opinions of a range of staff across the trust through a series of focus groups and behaviour / culture training sessions during 2016 - 2018.

The trust had an operational plan 2018/19. This had been developed in accordance with the NHS England and NHS improvement (NHSi) ‘Refreshing NHS Plans’ guidance (February 2018). The operation plan was approved by the trust board of directors and council of governors in March 2018. The operation plan included key objectives covering the following areas -

- Strategic Context
- Quality, Safety and Patient Experience Planning Priorities
- Operational Delivery
- Financial and Activity Planning
- Workforce Planning
- Membership and Elections

There was no overall trust strategy in place at the time of our inspection. The trust board was in the process of developing a long term strategic plan built on three strategic objectives:

- West Cheshire Way working with local healthcare and other related partners to drive service re-design and integrate care for the residents of Western Cheshire.
- Integrated Specialist Services providing the right services to meet the needs of patients, either as part of clinical network or as a specialist centre in our own right.
• Countess 20:20 reviewing core services to ensure they deliver the health outcomes and quality that patients deserve.

The trust did not have an active and current clinical strategy in place. There was an on-going plan in place for the development and implementation of this strategy. The interim medical director was the lead for implementing the clinical strategy and told us that consultation meetings involving staff and external stakeholders on the development of the strategy were scheduled to take place during January and February 2019. The clinical strategy was expected to be approved and in place by the end of March 2019. Progress on the implementation plan for the clinical strategy was monitored at weekly executive team meetings.

The trust did not have a mental health strategy in place at the time of our inspection. However, there was an active service level agreement with Cheshire and Wirral Partnership NHS Foundation Trust (CWP) in respect of psychiatry liaison service to support patients with mental health issues within the trust. The trust reported that this service level agreement was sufficient to satisfy a strategy.

The trust planned to develop a dementia strategy by the end of June 2019. The trust planned to introduce an integrated complex care team (combining the existing adult safeguarding and dementia teams) and a dementia steering group that would work to develop a dementia strategy by the end of June 2019.

The trust Informatics strategy (2016-2019) incorporated the trust’s three strategic objectives and outlined the approach to use of informatics and technology. The informatics director told us the strategy was in need of an update as it did not currently fully specify the planned electronic patient record system implementation project scheduled to commence in January 2019.

The nursing and midwifery strategy 2018 – 2020 outlined the trust’s commitment for nursing and midwifery staff in delivering. The strategy incorporated nationally recognised tools such as ‘6Cs’ and the ‘Model Ward’ programme and identified 10 objectives for implementation; including patient-centred models of care, skilled and flexible workforce, research and learning from incidents and complaints.

The People and Organisational Development Strategy and Delivery Plan 2016-18 incorporated the trust’s three strategic objectives and outlined key objectives such as values and behaviours, recruitment, e-rostering, equality and diversity and health and well-being. The strategy had not been updated for 2019 at the time of our inspection.

The trust had a strategy outlining key priorities for medicines management which included the replacement of automated dispensing systems, engagement with partner organisations in the Sustainability and Transformation Partnerships (STP), a seven-day service and exploring the use of pharmacy prescribers. The trust had also introduced pharmacist prescribing roles across the service and had started recruitment for pharmacists to provide a service to care homes.

Culture

There was strong patient focus, which included the wider community. We found the culture centred on the needs and experience of people who used services.

We received a mixed response from staff about the culture within the trust. Some of the staff we spoke with felt loyal and proud about working for the trust and working within their teams, which they described as like a ‘family’.
Most staff spoke positively about the support they received from their local team leaders. However, specific staff groups such as nurse practitioners and some specialist doctors described a poor culture of bullying and being less involved or excluded from local team meetings which had a negative effect on their morale. Some of these staff told us they felt disconnected from the senior leadership team because they felt they had raised their concerns in the past and their concerns had not been acted upon. We discussed this with the interim medical director, who was aware of concerns raised by staff and provided assurances that actions were being taken to engage with staff and improve the culture.

Some staff felt there was a lack of visibility from the senior leaders in the trust. The nursing, medical and support staff we spoke with described difficulties in the past in gaining approval for capital expenditure requests or requests for additional staff. Some staff told us during focus groups and the core service inspection that a lack of investment in the trust had resulted in staff leaving the organisation to work elsewhere, with better conditions and opportunities.

The consultants and senior medical staff we spoke with were positive about the interim chief executive officer (CEO) and told us they had been encouraged about investment in additional medical staff through recent engagement with the interim CEO.

Our discussions with staff during interviews, focus groups and the core service inspection highlighted that staff morale was low, especially in the surgical and medical wards. Staff felt they were overstretched due the high demands on the services. Staff in the medical wards told us staff moves to other wards to cover for staffing shortfalls also had a negative effect on their morale.

The Guardian of Safe Working Hours protects patients and doctors from working unsafe hours. They are in post to ensure that junior doctors, particularly those on new contracts have their work schedules given to them on time.

The guardian was always available to support and attended induction for trainees and produced an annual report which in 2017-18 highlighted the gastroenterology and respiratory specialties having the most frequent exceptions reported. As a result, a physician associate and additional junior doctors had been placed in these specialty areas to improve this.

The trust had appointed the following individuals as Freedom to Speak up Guardians:

- A non-Executive Director
- Director of Nursing and Quality
- Staffside Chair/RCN Representative (also the chief operating officer)
- Director of Legal and Corporate Affairs
- Director of People and Organisational Development

Staff were able to report any concerns through the trust intranet site. However, we found there was a lack of awareness among staff about the freedom to speak process. For example, in urgent and emergency care none of the staff we spoke with were aware of the freedom to speak up guardian role or the current post holders.

The trust reported four cases had been reported to the freedom to speak up process since November 2017. We saw evidence that these were investigated to make improvements to the services.

There was a plan in place to improve the freedom to speak up process across the trust. A dedicated Freedom to Speak up Guardian post had been advertised by the trust with interviews scheduled to take place in January 2019. The trust reported the new Freedom to Speak up Guardian would report directly to the chief executive and a key objective will be to develop a plan of recruiting Freedom to Speak up Ambassadors and implementing this by the end of June 2019.
The high-performance culture barometer group was made up of staff from across the trust and aspired to engage with the diverse staff groups within the trust. Members of the group were encouraged to actively contribute, to learn more about particular projects or processes and how they can be involved in those projects or processes and to network with other staff.

There were a number of initiatives in place to recognise and celebrate staff achievements. This included a staff recognition scheme, an annual ‘Celebration of Achievement’ awards ceremony, monthly ‘Countess Gems’ nomination and awards and the introduction of the 'Thank You Wall' for informal positive feedback for staff.

**Staff Diversity**

As of July 2018, Countess of Chester Hospital NHS Foundation Trust employed 4,798 people. Of these 11% of staff were from BME groups, with 98% of staff overall reporting their ethnicity.

*(Source: Trust workforce equality standard document – July 2018)*

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

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Qualified nursing and health visiting staff</th>
<th>Qualified nursing and midwifery staff</th>
<th>Medical and dental staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – British/Irish/any other white background</td>
<td>92.3%</td>
<td>95.6%</td>
<td>60.6%</td>
</tr>
<tr>
<td>BME British</td>
<td>3.7%</td>
<td>0.9%</td>
<td>17.1%</td>
</tr>
<tr>
<td>BME non-British</td>
<td>2.7%</td>
<td>0.0%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Not stated</td>
<td>1.3%</td>
<td>3.5%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

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

The trust has five 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>Key finding 20. Percentage experiencing discrimination at work in last 12 months.</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>Key finding 21. Percentage believing the organisation provides equal opportunities for career progression / promotion.</td>
<td>88%</td>
<td>85%</td>
</tr>
<tr>
<td>Key finding 29. Percentage reporting errors, near misses or incidents witnessed in last month.</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>Key finding 17. Percentage feeling unwell due to work related stress in last 12 months.</td>
<td>35%</td>
<td>36%</td>
</tr>
<tr>
<td>Key finding 26. Percentage experiencing harassment, bullying or abuse from staff in last 12 months.</td>
<td>22%</td>
<td>25%</td>
</tr>
</tbody>
</table>

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

The trust has 20 key findings that were 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>Key finding 12: Quality of appraisals.</td>
<td>3.04</td>
<td>3.11</td>
</tr>
<tr>
<td>Key finding 13: Quality of non-mandatory training, learning or development.</td>
<td>3.96</td>
<td>4.05</td>
</tr>
<tr>
<td>Key finding 28: Percentage witnessing potentially harmful errors, near misses or incidents in last month.</td>
<td>35%</td>
<td>31%</td>
</tr>
<tr>
<td>Key finding 30: Fairness and effectiveness of procedures for reporting errors, near misses and incidents.</td>
<td>3.59</td>
<td>3.73</td>
</tr>
<tr>
<td>Key finding 31: Staff confidence and security in reporting unsafe clinical practice.</td>
<td>3.57</td>
<td>3.65</td>
</tr>
<tr>
<td>Key finding 18: Percentage attending work in last 3 months despite feeling unwell because they felt pressure.</td>
<td>54%</td>
<td>52%</td>
</tr>
<tr>
<td>Key finding 15: Percentage satisfied with the opportunities for flexible working patterns.</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>Key finding 1: Staff recommendation of the organisation as a place to work or receive treatment.</td>
<td>3.70</td>
<td>3.75</td>
</tr>
<tr>
<td>Key finding 4: Staff motivation at work.</td>
<td>3.87</td>
<td>3.92</td>
</tr>
<tr>
<td>Key finding 7: Percentage able to contribute towards improvements at work.</td>
<td>69%</td>
<td>70%</td>
</tr>
<tr>
<td>Key finding 9: Effective team working.</td>
<td>3.67</td>
<td>3.72</td>
</tr>
</tbody>
</table>
Key finding 5: Recognition and value of staff by managers and the organisation.  | 3.39 | 3.45 |
---|---|---|
Key finding 6: Percentage reporting good communication between senior Management and staff. | 31% | 33% |
Key finding 2: Staff satisfaction with the quality of work and care they are able to deliver. | 3.85 | 3.91 |
Key finding 3: Percentage agreeing that their role makes a difference to patients / service users. | 89% | 90% |
Key finding 32: Effective use of patient / service user feedback. | 3.44 | 3.71 |
Key finding 22: Percentage experiencing physical violence from patients, relatives or the public in last 12 months. | 20% | 15% |
Key finding 23: Percentage experiencing physical violence from staff in last 12 months. | 3% | 2% |
Key finding 24: Percentage reporting most recent experience of violence. | 65% | 66% |
Key finding 25: Percentage experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. | 30% | 28% |

(Source: NHS Staff Survey 2017)

Staff Survey - Following receipt of the result of the Staff Survey an action plan was developed.

Workforce race equality standard

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></th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q17b</td>
<td>White 6%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>BME 11%</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>KF25</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.</td>
<td>White 30%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>BME 15%</td>
<td>28%</td>
<td>30%</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.</td>
<td>White 23%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>BME 15%</td>
<td>27%</td>
<td>23%</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.</td>
<td>White 88%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>BME 84%</td>
<td>75%</td>
<td>88%</td>
</tr>
</tbody>
</table>
None of the four questions above showed a statistically significant difference in score between white and BME staff.

(Source: NHS Staff Survey 2017)

BME applicants who were shortlisted accounted for 11% of the total for 2017. BME applicants accounted for 9% successful starters in 2017. The likelihood of shortlisted BME applicants to be successfully appointed to a position within the Trust had reduced from the previous year but remained higher than the BME local population.

There was a workforce race equality action plan (July 2018). This set out the actions required against each equality objective. The trust had implemented the action plan based on the WRES findings to improve outcomes for Black and Minority Ethnic staff as measured by the NHS staff survey.

However; in discussions with BME staff we were told that there was a feeling amongst staff in certain areas of the trust, that they were limited in their chances of promotion and lacked support from direct line managers.

The Equality Strategy 2017-2021: Annual update (2017-2018) outlined the following five objectives and specific actions were in place in relation to achieving these objectives: -

- Patient experience and satisfaction with accessibility and service provision follow national guidance with regard to all the protected characteristics
- Services, information and resources can be accessed by everyone
- Increase the awareness and competency of all staff in assessing and endeavouring to meet the diverse and individualised needs of people from across the protected characteristics
- Patient experience and satisfaction with accessibility and service provision follow national guidance with regard to all the protected characteristics
- Advance equality of opportunity for people who have a disability

The trust reported that the introduction of the Workforce Disability Equality Standard (WDES) had been postponed by NHS England until August 2019. However, in preparation for the standard, the trust had undertaken the following initiatives:

- Staff focus groups on managing disability in the workplace
- Extensive engagement on the creation of staff networks with both staff and relevant local stakeholders including the trusts Disability Equality Group
- The introduction of virtual staff networks for both disabled staff and staff who are carers (due to launch early 2019)
- Discussion on the promotion of access to work, flexible working and the trusts Occupational Health services in 2019

The trust had an equality and diversity manager who was responsible for the legal obligations and publications relating to equality and diversity. The remit of the role included equality and diversity for staff, patients and relatives, including training.

The equality and diversity manager had been in place since April 2018 and worked as the equality and diversity lead three days per week.
The equality and diversity manager reported to the deputy director of people and organisational development, with executive oversight provided by the director of people and organisational development, who was the executive lead for equality and diversity at the trust.

The equality and diversity manager told us they regularly engaged with representatives from BME, disability and LGBT groups across the trust and promoted equality and diversity across the trust.

The equality and diversity manager had conducted focus groups for BME, LGBT and disability staff groups during 2018. However, attendance was low because of staff being unable to attend due to work pressures. The equality and diversity manager confirmed there were currently no BME, LGBT and disability network groups in place and there was a plan to set up these networks during 2019. This included virtual (email) networks and a virtual human library to enable staff to engage online and access relevant information if they were unable to attend meetings.

Information from the trust showed that in August 2018, 97% of staff across the trust had completed mandatory training in equality and diversity. This was above the trust compliance target of 95%.

**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 worse than the England average for recommending the trust as a place to receive care for most of the period from August 2017 to July 2018. However, in September 2017, performance was about the same as the England average.

(Source: Friends and Family Test)
Sickness absence rates

The trust’s sickness absence levels from June 2017 to May 2018 fluctuated around the England average. Rates followed a similar trend to the England average throughout the period, with an increase in sickness rates over the winter period.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

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

(Source: General Medical Council National Training Scheme Survey)

Governance

There was a governance structure that supported the escalation of information and key risks to the trust board through various committees and assurance groups. There were five main sub-committees of the board, each chaired by a non-executive director. These were:

- The Quality, Safety and Patient Experience Committee (QSPEC)
- The Finance and Integrated Governance Committee (FIG)
- The People and Organisational Development Committee
- The Audit Committee
- The Remuneration Committee.

Structures, processes and systems of accountability were in place to support the delivery of quality services. All sub-committees of the board were chaired by a non-executive director (NED) and had clear terms of reference. The NED’s were engaged in quality governance. They told us they felt
they were sighted on most issues and did provide appropriate challenge, for example, an in-depth review of staffing. At least three NEDs attended each board sub-committee meeting to enable cross-working and oversight of the sub-committees they were not accountable for.

Structures, processes and systems of accountability were in place to support the delivery of services. The trust was divided into three service areas supported by corporate and operational services. Operationally each service area had a Safety, Quality and Standards Sub-committee which mirrored the content of the trust’s main Quality, Safety and Patient Experience Committee (QSPEC). These meetings took place on a regular basis and reported upwards by exception and to provide assurance.

The board reviewed its risks and Board Assurance Framework which set out the strategic risks which could impact on the delivery of the organisations’ objectives. The board scrutinised the assurance framework and corporate risk register to provide assurance that the strategic risks and the controls in place to mitigate the risk were appropriate and effective. There was a clear link between strategic risks on the board assurance framework and each sub-committee. Meeting minutes showed the relevant board assurance framework risks were reviewed at least every three months at the relevant board sub-committees.

There was a network of sub-committees and assurance groups that were led by executive directors that reported to the board five main board committees. Divisional governance board meetings were also held on a monthly basis and information was reported to the Quality, Safety and Patient Experience Committee (QSPEC).

The trust board and sub-committees received information through periodic reports, summary briefings and integrated dashboards to inform planning and decision-making. The board and committee papers we looked at showed that most of the information was relevant and available for committee members to review. However, we found that supporting papers lacked concise summaries to support the detailed information presented, which meant the information could be cumbersome to review and analyse. Meeting minutes showed that supporting papers were supported by a verbal commentary and reassurance from the accountable person(s) for that information.

We found examples where accountabilities were not clear or were covered across more than one committee; for example, the risk and performance committee reported to the Finance and Integrated Governance Committee (FIG) but aspects of risk were also covered by the Quality, Safety and Patient Experience Committee (QSPEC). The chair and board members acknowledged that the governance committee structure was not fully effective because there was a greater emphasis on operational performance rather than gaining assurance.

We identified the changes in senior leadership such as the appointment of the acting chief executive and acting medical director had led to recognition that improvements were required. The chief executive was in the process of commissioning an external review of governance processes that was planned to take place in February 2019 in order to strengthen the trust’s governance processes.

Executive team meetings were held on a weekly basis to support additional focus on performance and delivery of key business cases at executive level. We found that executive level governance structures and systems were articulated effectively but this was less so at corporate level. For example, executive meetings reviewed risks and performance in detail whereas an overview was submitted to trust board.

We found evidence that the trust were compliant with the duty of candour requirements. This states the trust must act in an open and transparent way about the care and treatment patients
receive and notify them, as soon as is reasonably practicable, after becoming aware that a notifiable safety incident has occurred, firstly in person and then in writing.

The trust had an in date Duty of Candour policy and procedure. The Director of Nursing and Quality was responsible for the duty of candour process and the Medical Director was responsible for clinical decision making in relation to duty of candour. Cases triggering a duty of candour were monitored at the weekly serious incident (SI) panel. The incidents we reviewed showed that a duty of candour discussion had taken place with the patient or relative.

The Director of Nursing was the executive lead for safeguarding adults and children. The Trust Board received an annual safeguarding report. There was a structure to support safeguarding concerns. We discussed the reasons for non-compliance with safeguarding training targets. The trust was aware of this and was looking at alternative ways for staff to access training. The named and designated professionals for safeguarding met regularly with the Director of Nursing to review policy, lessons to be learned from reviews both locally and nationally. There were audit programmes to ensure that safeguarding systems and processes were functioning effectively.

In line with best practice, ward staff were supported to care for patients with presenting mental health conditions through the provision of psychiatric liaison staff employed by the nearby mental health trust. There were good working relationships with the liaison team. Ward staff told us they received a timely response to referrals to the service and would also ring and ask for advice and information. Staff within the mental health liaison team and staff in all divisions valued each other’s input and commented that the service worked well together to meet patients’ physical and mental health.

Policies and procedures were available on the trust intranet sharepoint system. The trust reported in December 2018 that there were 2038 policy / procedure documents of which 376 (18.4%) were overdue for review. The trust reported that an alert system notifying the document owner that a document is due for review was put in place in November 2018 and the executive team were monitoring compliance to reduce the number of overdue documents.

Management of risk, issues and performance

Trust corporate risk register

The trust provided a document detailing their nine corporate risks. Three of these, which are shown in the table below, had a red RAG rating indicating a current risk score of 16 in 2018/19 quarter 2.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Latest Risk level target</th>
<th>Date of latest risk target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR2</td>
<td>Unable to meet the demand for services within available resources.</td>
<td>16</td>
<td>8</td>
<td>March 2019</td>
</tr>
<tr>
<td>CR4</td>
<td>Failure to implement People and Organisation Development Strategy &amp; Delivery Plan.</td>
<td>16</td>
<td>12</td>
<td>April 2019</td>
</tr>
<tr>
<td>CR6</td>
<td>Failure to comply with Compliance Framework.</td>
<td>16</td>
<td>6</td>
<td>March 2018</td>
</tr>
</tbody>
</table>

(Source: Board assurance framework)
The Board were aware of the challenges in the organisation to ensure quality of care and patient safety.

There was a trust risk management strategy in place; however this was in the process of being updated at the time of our inspection. The risk management strategy outlined the roles and responsibilities of the trust board, board sub-committees and divisional and specialty-level staff in identifying, managing and monitoring risks to the organisation.

The director of nursing was accountable for risk management processes and maintaining the board assurance framework (BAF). The operational lead for risk management and maintaining the trust risk register was the associate director of risk and safety, who reported to the director of nursing.

The BAF set out the strategic risks that could impact on the delivery of the trust’s objectives. The BAF was reviewed by the executive team at the Risk and Performance Committee and at the Quality, Safety and Patient Experience Committee (QSPEC). The executive team reviewed the BAF to provide assurance that the strategic risks and the controls in place to mitigate the risk were appropriate and effective. Individual risks on the BAF were also reviewed by sub-committees of the board for oversight. All BAF risks were reviewed at QSPEC and the trust board received assurance through a board summary / overview supported by a verbal update from the director of nursing to the board. The meeting minutes we looked at showed evidence that individual BAF risks were reviewed at executive meetings and board sub-committees but did not clearly demonstrate that all BAF risks were reviewed in detail at board meetings.

The Risk and Performance Committee was chaired by the chief executive and reviewed newly escalated and considered whether to accept them onto the trust risk register. Trust risk register risks scoring greater than 16 were reviewed monthly at the Risk and Performance Committee and aligned to the board assurance framework.

There was a weekly serious incident (SI) panel that was attended by the medical director, associate medical director for risk, director of nursing and the associate director of risk and safety. The SI panel also has representatives from patient experience group and litigations / legal services. Incidents, complaints and claims were reviewed at the SI panel to determine external reporting requirements, to determine level of investigation required and to determine if incidents needed to be placed on divisional or trust risk registers.

The executive team formally reviewed the trust (executive) risk register every three months at the executive team meeting. There was a clear process for escalation of risks from ward to board. Each clinical area / department maintained local risk registers. Risks and incidents at ward level were managed by clinical leads and ward managers with support from divisional governance leads. Risks scored greater than 12 were reviewed at divisional governance meetings and placed on the divisional risk register(s). Each division had a governance lead that support for staff, monitored incidents and identified risks to be placed on the risk register(s). The divisional boards reported to QSPEC.

We reviewed the trust risk register and divisional risk registers and found these were up to date. Risks included date of addition to register and review dates. Each risk was assigned to a lead with accountability for the risk. Risk scores were updated and appeared to be consistent with the level of risk and mitigating actions recorded. The risks detailed in the registers were reflective of those highlighted to us by staff and broadly correlated with our findings during the inspection. However, the trust and divisional risk registers did not contain additional information such as summaries of action plans or mitigating factors. The associate director of risk and safety told us the trust used an
There were processes in place for the reporting, investigation and learning from incidents. Reported incidents, complaints and patient deaths were reviewed at a weekly serious incident (SI) panel that was attended by the medical director, associate medical director for risk, director of nursing and the associate director of risk and safety. The SI panel also had representatives from patient experience group and litigations / legal services.

Incidents, complaints, claims were reviewed at the SI panel to determine external reporting requirements, to determine level of investigation required and to determine if the incidents needed to be placed on the divisional or executive risk registers. The serious incident panel covered duty of candour guidance, looked at trends and themes and also could commission deep dive investigations for recurrent issues, such as falls with harm.

Serious incident investigations were allocated to independent lead investigating officers and there were approximately 50 multidisciplinary staff that had received root cause analysis training. Monitoring of actions was carried out at divisional governance boards and the associate director of risk and safety produces produced a monthly exception report that was submitted to the Quality, Safety and Patient Experience Committee.

We looked at all the serious incident investigations completed during 2018. These were completed to a good standard and contained appropriate information, action plans and evidence of learning and improvement. There was evidence of comprehensive investigations having been undertaken with root cause analysis, chronology (timeline of events) and a review of business continuity arrangements recorded. The incident reports detailed the involvement and support provided for staff involved in the incident as well as support for patients and relatives (such as duty of candour principles). The reports included a section which highlighted good practice identified during the investigation. Action plans had lead responsibilities and completion dates recorded.

The Medical Director had delegated accountability for mortality at board level and had responsibility to monitor, review and receive assurance on the effective implementation of national and local strategies targeted at reducing preventable mortality in accordance with patient choice, reducing adverse events, improving outcomes and quality of care for patients. The Medical Director provided the quarterly mortality dashboard to the trust board and, in conjunction with the Chair of the Learning From Deaths Group, a quarterly mortality report to trust Quality, Safety and Patient Experience Committee (QSPEC).

Clinical and corporate teams worked with external organisations to assess and manage risks to safety, for example safeguarding teams, GP practices, and mental health teams.

At an operational level there was a process for staff to share learning from mortality reviews. However, in some areas for example, medicine staff we spoke with reported they did not always receive feedback following a mortality review of a patient from their ward.

The Medicines Management Team completed an annual medicines management audit and an interim mini audit of the Trust. It included medicines safe storage, security of controlled drug stationary and date checking of medicines. The mini audit completed in May 2018-showed that compliance with recording of daily fridge temperature monitoring was variable in some ward or critical care areas. An Action plan to be completed by October 2018 was to provide feedback to ward and clinical area managers on the issues raised. However, the core service inspection highlighted concerns around medicine safe storage across medical care, surgery and urgent and
emergency care which meant that remedial actions had not been fully implemented following the trust’s medicines management audit.

A monthly incident report was produced by the medicine safety officer based on collated reports. These were then shared with the Pharmacy Incident Review Group; these included specific categories, incident trends and those incidents with significant learning requirements. These were then presented, at a Medicine Safety committee, the department produced Safety Medicines Bulletins and Medicines in a minute guidelines (MIM).

We looked at ten serious incident investigations completed during 2017/18. These were of a good standard and contained appropriate information, action plans and evidence of learning and improvement.

The acting medical director was the director of infection prevention and control (DIPC) and was supported by an infection prevention and control team consisting of infection control nurses, consultant microbiologists and administrative support. There was an Infection Prevention Committee that held meetings every two months and reported to the Quality, Safety and Patient Experience Committee (QSPEC).

The trust reported that between April 2018 and November 2018 there had been:

- 19 cases of C. Difficile infections reported. This was higher than the target trajectory of 11 for November 2018 (target for 2018/19 was 23).
- Three MRSA Bacteraemia infections (post 48-hour avoidable) against a target of zero. All these occurred in different wards / areas of the trust.

The trust also monitored infection rates for other organisms (such as MSSA, E.coli. P. Aeruginosa and gram negative bacteraemia infections) and reported these as part of the West Cheshire infection control network.

Staff told us all C Difficile and MRSA bacteraemia infections were investigated with input from the infection prevention and control team to identify the root cause and look for improvements. We looked at five incident reports for C.diff. We found these to be to clear and detailed.

The trust implemented a tele-tracking (patient tracking system) in two phases during February 2017 and December 2017. This system enabled the trust to obtain information such as length of time beds remained empty and enabled notifying porters if a patient was ready for transfer and the bed change team if a bed was ready to clean. The informatics director told us the trust had the capability to obtain information about the effectiveness of the tele-tracking system but had not carried out any monitoring or audit activities to measure the effectiveness of the system.

We identified that some improvements had been made since our last inspection in February 2016. However, we found a number of areas for improvement from the previous inspection that had not been fully addressed as part of this inspection. This included areas such as the safe storage and management of medicines and staff application of the mental Capacity Act 2005 principles deprivation of liberty safeguards. This showed that effective learning and improvement had not been made in these areas since our previous inspection.
The trust had a planned turnover of circa £230m in 2018/19. The trust had historically been financially stable but with an underlying deficit of approximately £10m. In 2017/18 the trust reported a surplus of £1.7m, which was better than its annual plan and control total largely due to the award of additional sustainability and transformation funding at year end.

The trust had achieved its financial targets in the last two financial years after adjustments were made to the targets during the year, but the trust’s financial position had deteriorated in 2018/19. At the time of the inspection in December 2018 the trust had forecast that it will not achieve its control total for 2018/19, with an expected variance of £8.4m (excluding provider sustainability funding), giving an in-year deficit of £13m. At the time of the inspection the trust was predicting that it would access distressed revenue funding for the first time during 2018/19. The trust’s financial position is under regular scrutiny with NHS Improvement.

The board approved a financial plan for 2018/19 in April 2018 but very soon afterward starting to signal to NHS Improvement that the plan would not be delivered. In September 2018, the trust revised the forecast for 2018/19 and declared an £8m variance to plan. This was because a number of key risks, such as savings delivery, could not be mitigated.

There was a process in place for the submission and approval of quality impact assessments (QIA). The interim medical director and director of nursing were both responsible for approving QIA submissions. Records showed there had been 10 QIA submissions made during 2018/19. Of these, three were on hold, three had been approved, two had been deferred, one rejected and one awaiting approval. Business cases were reviewed at monthly cost reduction strategy (CRS) meetings.

**Information management**

The board, its sub-committees received information through board and committee papers, progress reports, meeting minutes and integrated performance dashboards. The chief operating officer told us data was captured in real-time and there was confidence that the data used in integrated performance reports was accurate and up to date. However, it was unclear if any audit / monitoring had taken to place to gain assurance about the accuracy of data submitted to the board and its sub-committees.

The director of nursing and quality was the appointed Senior Information and Risk Owner (SIRO) and had held this role for the past six years. As part of the role, the SIRO attended external
training annually to keep up to date with current guidance. The medical director was the Caldicott Guardian and worked closely with the SIRO.

The chief financial officer was responsible for IT strategy development. The trust’s Informatics Strategy (January 2016 to December 2019) outlined the three-year plan for the digitalisation of processes within the trust. The informatics director told us this was due to be refreshed to incorporate the electronic patient record (EPR) project that was due to commence in January 2019.

There was an informatics director in place that had responsibility for IT infrastructure, IT service support desk, electronic patient record / clinical systems implementation and IT project and programme delivery. The director of informatics reported to the director of finance but had a close working relationship with the SIRO.

The informatics director told us that management of data quality / coding was transferred to the chief operating officer and responsibility for health records went to the director of estates approximately 18 months ago. This meant that elements of information technology were shared among three separate reporting structures instead of being part of one combined function.

The SIRO and informatics director attended the informatics board, which held meetings every two months and reported to the Finance and integrated governance (FIG) Committee. There was also an Information Governance Committee that held meetings every two months and was attended by the medical director (Caldicott), SIRO and data protection officer.

Information from the trust showed that in August 2018, 85.2% of staff across the trust had completed mandatory training in information governance. This was below the trust compliance target of 95%.

The trust had arrangements in place to ensure that data or notifications were submitted to external bodies as required. Incidents, including serious incidents, were reported as required to the NHS national reporting and learning system or the NHS strategic executive information system. Staff across the trust could access information through meetings, updates, newsletters and through the trust’s intranet site.

The trust planned to start the implementation for an electronic patient record (EPR) system from January 2019 onwards with a launch date planned for later in 2019. There was a project plan in place that outlined the initial actions and due dates for these. The EPR system implementation was overseen by the informatics director and was being developed in partnership with a neighbouring NHS trust that had already implemented this system.

The trust had completed the information governance (IG) toolkit submitting an 82% satisfactory rating (attainment level 2 or above) in March 2018. The Mersey Internal Audit Agency (MIAA) also carried out an internal audit of information governance processes and significant assurance provided. Improvement actions following the audit focused on the new data security and protection toolkit with a work plan had been developed to implement this during 2019.

The trust had processes in place for the reporting and management of cyber security risks. There was an appointed cyber security lead in the trust. There had been no reported cyber security breaches and the trust was not impacted by cyber breach issue that affected other trusts during 2017/18. The SIRO reported that information governance issues were reported to the Information Governance Committee. The trust reported one information governance breach to the Information Commissioner's Office (ICO) during in January 2018 and we saw evidence this had been resolved and confirmed with ICO.
Engagement

The national NHS staff survey (2017) showed the trust scored 3.75 (out of five) for an overall indicator of staff engagement. This was below average (3.79) when compared with other acute trusts nationally. The 2017 staff engagement score was also worse than the 2016 survey score (3.77).

We received a mixed response about the level of staff engagement from staff focus groups and staff interviews during the inspection. The majority of nursing staff, consultants and support staff spoke positively about the level of engagement and support they received. We received mixed comments from other staff groups (such as middle grade and specialty doctors) in relation to the level of engagement and support they received from the senior management.

Staff engagement took place through a variety of methods, including focus groups, staff surveys, induction welcome events, blogs, correspondence updates and newsletters. The ‘What’s Brewing’ formal staff engagement sessions were held weekly across different parts of the trust. The sessions were published on the trusts’ website and all staff emails are circulated to all staff through email to raise awareness of each session. They were facilitated by members of the trusts’ leadership team and executives.

Board members told us that they actively engaged with the governors and members of the trust. Governors we spoke with were involved with the trust and received regular updates on how the trust performed. Governors were invited to attend board meetings and walkabout visits.

The trust reported that the executive director of people and operational development held 1:1 meetings with the staff side representatives’ chair on a monthly basis and there was a standing open access policy for the staff side chair to meet with the chief executive and trust chairman when required. Staff side members we spoke with confirmed this.

There were a number of patient and public engagement initiatives being delivered by the trust. Examples included: -

- The Governors’ feature in the trust newsletter, three times per year.
- Promotion of Annual Members Meeting each year
- Patient Association – The One Show
- Friends and Family test feedback on social media platforms.
- Direct interaction with patients through social media platforms including signposting to patient experience messages set up for those people who have a poor experience.
- Interaction and engagement with children across local schools to raise awareness on issues such poppy appeal / knitted poppies.
- Support national campaigns from groups such as Healthcare Safety Investigation Branch ‘Be Battery Aware’ campaign.
- Support for NHS England, clinical commissioning group (CCG), local authority and Public Health England campaigns
- Support for Chester Safe Space and other Cheshire West and Chester Council campaigns
- Promotion of Park and Ride and other alternatives to accessing the Countess of Chester hospital site.
- Promotion of ‘End Pyjama Paralysis’ within the hospital.
• Promotion of awareness raising campaigns such as SEPSIS and “Stop the Pressure” (pressure ulcers).

During our core service inspection, we found varied knowledge, training and application of sepsis care across the areas we inspected. Staff in urgent and emergency care and some surgical wards had received additional training as part of the trust’s sepsis awareness programme and had a good understanding of how to manage patients with sepsis. However, staff across a number of medical and surgical wards that had not received additional training did not have a good understanding of identification and management of patients with sepsis.

The trust routinely engaged and collaborated with other regional healthcare providers. The trust was a member of the Cheshire West Integrated Care Partnership (CWICP). There were regional collaborative groups for integrated health services (such as intermediate care and therapy) and for information management and technology projects.

The trust engaged with local commissioners, NHS improvement and local GP service representatives. There was close partnership working with the Cheshire and Wirral Partnership NHS foundation Trust in the emergency and emergency care services. Feedback from stakeholders we spoke with demonstrated there was positive engagement from the trust.

Senior management acknowledged there were challenges due to Welsh patients admitted to the trust for care and treatment and further engagement with Welsh health authorities was ongoing to resolve issues relating to delayed transfer of care for these patients.

Learning, continuous improvement and innovation

Staff at the trust had developed the Peer Assessment after Clinical Exposure (PACE) program. This was designed to support staff following stressful/traumatic exposure through education on stress reactions and how they manifest. The PACE programme was piloted over a six-month period and a research study was done to determine the efficacy of the service. The PACE education programme was being rolled out across the trust with an aim to obtain accreditation for the course through the British Psychological Society.

There were a number of estates refurbishment / improvement projects planned across the trust. The main theatre areas were undergoing refurbishment work to improve storage facilities. A major refurbishment programme for the emergency department had commenced at the time of our inspection. The project was planned in two phases due for completion in 2020 and initially involved increasing car parking and patient waiting area capacity followed by a redesign of the emergency department in order to improve patient flow, efficiency and the patient experience. The trust was granted planning permission in December 2018 to extend the existing neonatal unit to provide family integrated care, improve the quality of the environment, meet current standards and reduce risk through the clearance of backlog maintenance.

The trust was also involved in a number of improvement projects, including: -

• The implementation of a new electronic patient record system, with the project due to commence in January 2019.

• The rollout of the national early warning score (NEWS) 2 across the trust.

• Quality improvement projects as part of the model hospital 2018/19 plan to improve and implement efficiencies in areas such as theatre efficiency, outpatient services, medical staff rostering, get it right first time (GIRFT) and the model ward programme.
Learning from Inpatient Deaths

There was evidence of learning from the death of patients, and support given to families and carers through any investigation process. The Learning From Deaths Group oversaw the mortality review process and shared learning and reported to the Quality, Safety and Patient Experience Committee (QSPEC).

Each department held regular mortality and morbidity meetings and these fed in to the divisional governance boards. The trust had implemented the structured judgement review (SJR) process for learning from individual deaths. The structured judgement reviews were carried out by a team of 10 trained staff with further training planned in March 2019 to increase the number of staff trained in the SJR methodology. The trust reported that as of end of November 2018, 61 structured judgement reviews had been completed and a further 14 deaths were investigated as part of the Serious Incident framework. This accounted for 6% of all deaths (1023) in the previous 12 months.

The trust reported that a short mortality screening audit form was to be introduced in January 2019 to review all deaths in the trust which will complement the current speciality mortality and morbidity review process and also feed into the structured judgement review process.

We reviewed 10 mortality investigation reports and structured judgement review during the inspection and these were completed appropriately.

The Summary Hospital-level Mortality Indicator (SHMI) placed the trust in the "as expected" category with an outcome of 102 for the twelve months from October 2016 to September 2017. The Hospital Standardised Mortality Ratio (HSMR) was 105 in the 12 months from September 2017 to August 2018. This placed the Trust in the “as expected” category.

Learning from incidents was shared across the trust in a variety of ways; through the incident reporting system, through alerts and staff newsletters. The serious incident panel produced a ‘lessons learned’ memo email that was circulated to all staff each week. Learning was also discussed with staff through routine department and divisional level meetings.

Complaints process overview

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

<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>No target</td>
<td>n/a</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>40 working days</td>
<td>100%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints</td>
<td>65 working days</td>
<td>100%</td>
</tr>
<tr>
<td>please indicate what that is here</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>1,841 (26 July 2017 to 25 July 2018)</td>
<td></td>
</tr>
</tbody>
</table>

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

The trust received 223 complaints from 26 July 2017 to 25 July 2018. The surgery core service received the most complaints with 86.

<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>86</td>
<td>38.6%</td>
</tr>
<tr>
<td>Medical care</td>
<td>50</td>
<td>22.4%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>38</td>
<td>17.0%</td>
</tr>
<tr>
<td>Not core service specific</td>
<td>11</td>
<td>4.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>9</td>
<td>4.0%</td>
</tr>
<tr>
<td>Community Inpatients</td>
<td>7</td>
<td>3.1%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>7</td>
<td>3.1%</td>
</tr>
<tr>
<td>Maternity</td>
<td>6</td>
<td>2.7%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>4</td>
<td>1.8%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>3</td>
<td>1.3%</td>
</tr>
<tr>
<td>Community Children, Young People and Families</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>223</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

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

The associate director for risk and safety submitted a complaints, incidents and litigations report to the Quality, Safety and Patient Experience Committee (QSPEC) every six months. The April 2018 – September 2018 highlighted that improvements had been made in the overall complaints handling processes.

We saw evidence that complaints were shared with staff and learning was shared during the core service inspections. For example, in surgery we saw additional training was given to the planned care and waiting list teams to improve an error identified which caused a delay in treatment. The medical wards produced action plans to improve patient waiting times following feedback through patient complaints.

Compliments

From 26 July 2017 to 25 July 2017, the trust received a total of 130 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>42</td>
<td>32.3%</td>
</tr>
<tr>
<td>Surgery</td>
<td>33</td>
<td>25.4%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>22</td>
<td>16.9%</td>
</tr>
</tbody>
</table>
### 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 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>Services accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy (October 2017)</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>UKAS Accreditation for ISO 15189:2012 - Medical Laboratories granted for the pathology department in March 2018. This included: cellular pathology, haematology, clinical biochemistry, blood transfusion, immunology, non-gynaecology cytology.</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>Macmillan MQEM award – Ward 60 haemato-oncology unit renewed in May 2018 Macmillan Support and Information Centre – due for renewal December 2018</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)
The Countess of Chester Hospital NHS Foundation Trust consists of a 600-bedded large district General Hospital, which provides its services on the Countess of Chester Health Park. The Countess of Chester is the main NHS hospital for Chester and the surrounding areas. The urgent and emergency care services are managed by the Countess of Chester Hospital NHS Foundation Trust. The department also acts a trauma unit. The main accident and emergency department at the Countess of Chester Hospital is comprised of five main units:

- Emergency department
- Ambulatory Majors department
- Emergency Multidisciplinary Unit (EMU)
- Direct GP referral unit (GPU)
- Emergency Assessment Unit (EAU)

The hospital also has an Urgent Treatment Centre for primary care presentations delivered in collaboration between Cheshire Wirral Partnership and the Countess of Chester Hospitals, which was reviewed as part of this inspection, since it had staff from the Countess of Chester who worked in the centre.

The emergency department operates 24 hours a day, seven days a week. There was a relatively small waiting area in the entrance to the department, however during inspection we were shown the plans for the building work to the department, which would result in a larger waiting area, with a separate children’s waiting area. There was also a separate entrance for ambulances to bring patients into the department, with another separate ambulance access straight into the resuscitation area.

Ambulance off-loading bay had only been in operation for 12 months at the time of inspection and this was overseen by a the ‘time critical nurse’ who would take the hand over from the paramedics, however at night, this nurse would also oversee the streaming of patients attending the waiting room.

The emergency unit was comprised of 14 cubicles, with three side rooms. There was also a resuscitation area, comprising of three trolley spaces containing vital emergency equipment. The minors’ area of the unit was led by Emergency Nurse Practitioners (ENP) and within this area, was a separate new children’s waiting area (‘Kids zone’), which had a glass front with different coloured patterns on the window. This area was brightly coloured inside, with a separate toilet enclosed in the waiting room, a small television and an array of different toys.

The Emergency Multidisciplinary Unit (EMU) opened in the summer of 2017 and was based in what used to be the waiting area for the department and this operated between the hours of 9am to 5pm Monday to Friday. Each morning the manager for this department would review the patients within the department, to see which patients would be most suitable to come to the Emergency Multidisciplinary Unit. Within this unit, there was a hospital based Social Worker and both Physiotherapy and Occupational Therapy staff would attend the unit to see which patients they could assist.
The Emergency Assessment Unit (EAU) was an 11-bedded area, which was split into five and six beds, to accommodate female and male patients separately. The direct GP referral unit (GPU) received medical attendances between the hours of 9am to 10 pm; with the last referral at 7pm. Patients seen here had been referred by medics to the unit. All patients attending the department were streamed through the direct GP referral unit and this was run by both a GP and an Advanced Nurse Practitioner (ANP).

A Clinical Decisions Unit (CDU) was within the department, but this was comprised of chairs, there were no beds.

The Urgent Treatment Centre (UTC) operated from 9am until 9.30pm, but the staff from the unit were mainly employed by another provider, however one of the Advanced Nurse Practitioners (ANP) would review patients in the first instance and then stream them to the most appropriate area for treatment. The other provider also provided secondary streaming. At 5pm, this unit was overseen by one of the out of hours GPs.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. The inspection took place over three days and during this time we spoke to eight patients and carers and 38 staff members, inclusive of senior leaders, managers, medical and nursing staff, students and domestic staff. We reviewed a total of 15 patient records, 14 prescription charts and observed daily activity and clinical practice within the department. We also reviewed data relevant to the department that we received before and after the inspection which was provided by the trust.

Details of emergency departments and other urgent and emergency care services

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

Activity and patient throughput

From June 2017 to May 2018 there were 84,550 attendances at the trust’s urgent and emergency care services as indicated in the chart below.

Total number of urgent and emergency care attendances at Countess of Chester Hospital NHS Foundation Trust compared to all acute trusts in England, June 2017 to May 2018

(Source: Hospital Episode Statistics)
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in 2017/18 compared to 2016/17. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from June 2017 to May 2018

* Discharged 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)
Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trust had set a target of 95% for the completion of all mandatory training and this training included modules on equality and diversity, infection prevention (level two), resuscitation, moving and handling, paediatric basic life support, fire safety, health and safety (slips, trips and falls) and information governance. Except for Information governance for both nursing and medical staff, the trust was compliant for all other modules at the time the data was requested.

After initial training for each module needing to be completed, many of the modules would require staff to attend for a refresher session and the time scale for this varied depending on which specific module it was.

Staff also completed conflict resolution training every three years to aid with de-escalation; however, staff also told us that some sessions had been cancelled on the day, due to staffing issues, as the security manager delivered these.

Regarding training on the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards, following inspection we were told that all band six and band seven staff undertake the training as listed and the matron within the department had also undertaken further training delivered by the safeguarding lead. Further updates and training were included in the ‘Breakfast Club’ sessions and these were delivered by a member of the psychiatric liaison team.

Mandatory training completion rates

The Countess of Chester Hospital

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

A breakdown of compliance for mandatory training courses from July 2017 to June 2018 for qualified nursing staff in urgent and emergency care at The Countess of Chester Hospital below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>82</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>80</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>80</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>80</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>80</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>80</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>80</td>
</tr>
<tr>
<td>Information governance</td>
<td>76</td>
</tr>
</tbody>
</table>

In urgent and emergency care the target was met for seven of the eight mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from July 2017 to June 2018 for medical staff in urgent and emergency care at The Countess of Chester Hospital is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>25</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>25</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>25</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>25</td>
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<td>Health and safety (slips, trips and falls)</td>
<td>25</td>
</tr>
<tr>
<td>Information governance</td>
<td>18</td>
</tr>
</tbody>
</table>

In urgent and emergency care the target was met for seven of the eight mandatory training modules for which medical staff were eligible.

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

**Safeguarding**

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

At the time the data was requested, neither nursing or medical staff met the trust target of 95% compliance for the completion of safeguarding training, however, during inspection we spoke with the Director of Nursing and Quality who oversaw both adult and children’s safeguarding, as well as the specialist nurse for safeguarding children and the lead nurse for safeguarding adults, who also oversaw learning disabilities. We were told that adult safeguarding training was completed electronically, but the trust was now looking at effective ways to enable them to deliver level three safeguarding adult training to all clinically registered staff on a face to face basis, as this was now a requirement as set out by the ‘Intercollegiate document: - ‘Adult Safeguarding: Roles and Competencies for Health Care Staff’, first edition (August 2018). The leads we spoke to told us that this would be a huge task for the trust to complete, but senior managers were aware of this and work was being completed around this.

On discussion with one of the safeguarding leads, we were told that level three safeguarding children’s training was delivered face to face on an annual basis, in addition to electronic learning and we were told that all staff within the emergency department were trained in level three safeguarding children. As part of the training, topics such as female genital mutilation and child sexual exploitation were also covered.

Within the emergency department, staff were competent in knowing what to do if any form of abuse was suspected and that staff knew how to contact medical photography if this was needed and the Police would also be contacted. We were told that every child up to the age of 18 years was on a computer system which the trust had access to, to check if they were involved with Social Care, so staff would access this as part of the admission process. Safeguarding referral forms were available within the department and referrals would be made to Social Care as required. There was also a referral box within the department, which the safeguarding leads would review daily Monday to Friday and they would ensure all the necessary referrals had been sent.

Within the department we saw the flow charts used if safeguarding issues arose and these charts also detailed how to make a referral to the local authority and had the different local authority
contact details. These charts were clear and appeared easy to follow. Staff we spoke to felt supported in managing safeguarding issues and all the staff we spoke to were familiar with how to contact the safeguarding team for advice or support.

We reviewed the safeguarding policy in relation to children and saw that it had relevant agency contact details and included information to advise on different categories of abuse, the ‘Risk and Vulnerability Matrix’ diagram taken from the ‘Working Together to Safeguard Children’ document (2015), as well as the Cheshire west and Chester Continuum of Needs, with clear details of processes to follow if any abuse is suspected. The policy also clearly indicated that pregnancy in a child under 13 years should always be viewed as a child protection issue. Staff we spoke to were aware of the policy and how to access it, as well as familiarity with other safeguarding information and the referral process. We also saw sight of the Pan-Cheshire Guidelines for The Management of Sudden Unexpected Death in Infants and Children (SUDIC), with clear guidance on how to manage a sudden unexpected death in children within the department.

We were also told that if domestic abuse was suspected, or disclosed and the victim was at immediate risk, action would be taken straight away, as there was an emergency duty team based within the hospital, so if needed safe accommodation could be sought, or discharge could be delayed ensuring the safety of the victim. Routine assessments within the department contained a risk indicator checklist that helped to highlight potential victims and anyone subject to Multi Agency Risk Assessment Conference (MARAC), would be highlighted on the computer system.

In relation to access to safeguarding supervision, we were told that safeguarding supervision was done as it was needed and if staff phoned for advice or support, this was recorded and documented accordingly, in relation to adult safeguarding however, we were told that there was no formal supervision, as there was only one lead nurse in post, so with a large adult nursing staff population to cover, she did not have capacity to do this.

Regarding children attending the department, attendances in the last three months and 12 months were detailed. Any frequent attenders would be picked up by paediatric liaison who came to the department each day Monday to Friday and were employed by another trust. It was a mandatory duty to report any episodes of female genital mutilation (FGM) and the leads told us that they had strong links with local safeguarding boards.

**Safeguarding training completion rates**

**The Countess of Chester Hospital**

The trust set a target of 95% for completion of all safeguarding training courses. During inspection we were told that level three safeguarding children’s training was delivered face to face, with an additional online training module. The trust overall compliance was 82% and safeguarding staff told us that they were aiming for 85/90%.

Training figures for safeguarding adults for the department were 85.11%. A breakdown of compliance for safeguarding training courses from July 2017 to June 2018 for qualified nursing staff in urgent and emergency care at The Countess of Chester Hospital below:

<table>
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<td>Staff trained</td>
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<tr>
<td>Safeguarding adults (level 2)</td>
<td>76</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>71</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 and 2</td>
<td>64</td>
</tr>
</tbody>
</table>
In urgent and emergency care the target was not met for any of the three safeguarding training modules for which qualified nursing staff were eligible.

Following the last inspection in 2016, the trust was advised that it must ensure that there were sufficient staff trained in adult and children’s safeguarding procedures in the accident and emergency department. On speaking to one of the leads, we were told that all staff within the department were required to complete safeguarding level three children’s training. Out of 120 possible staff members, in October 2018, 107 had completed the training, giving a compliance rate of 89.17%.

A breakdown of compliance for safeguarding training courses from July 2017 to June 2018 for medical staff in urgent and emergency care at The Countess of Chester Hospital is shown below:

<table>
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<td>21</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>20</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 and 2</td>
<td>16</td>
</tr>
</tbody>
</table>

In urgent and emergency care the target was not met for any of the three safeguarding training modules for which medical staff were eligible.

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

**Cleanliness, infection control and hygiene**

We found that issues in relation to cleanliness, infection control and hygiene highlighted in the last inspection in 2016 had not been resolved. There was a lack of cleaning rotas within the department. During this inspection, it became evident that this remained an issue and after speaking with domestic staff, we were told that they did not complete any documentation during, or at the end of their shift to evidence what cleaning had been completed. Staff we spoke to, told us that as domestics they knew what jobs needed to be done, which was listed on the schedules we saw displayed, but there was nowhere for them to sign to say that those jobs had been completed on that shift.

Within the ‘kids zone’ paediatric waiting area, there were toys available for the children to play with, however on asking staff it was not clear who took responsibility for the cleaning of the toys and we saw no evidence of any cleaning schedule to account for the regular cleaning of them.

The department did not appear to be dirty, but there were areas which appeared very worn. We also saw evidence of a used incontinence sheet hanging over a bin in the plaster room, although this was not soiled, the bin lid was open.

We observed staff using personal protective equipment prior to delivering patient care, although we did not always see staff washing their hands. There were signs to encourage hand washing for relatives, carers and visitors. Hand gels were available in all areas of the department, although on entry to the department from the main hospital corridor, there were no hand gels available until getting much further inside the department.

There were plenty of handwashing sinks to use and dispensers for aprons and various sized gloves, which were all fully stocked, however, as the ambulance hand over area had previously been a storage area, there was no sink available for the time critical nurse, or anyone else to use...
immediately within that area. However, we did see hand gel available and we did observe this being used.

Whilst on inspection, we observed all clinical staff adhering to ‘bare below the elbow’ infection, prevention and control protocols.

Whilst reviewing the hand hygiene audits for the department over the months of May to August 2018, we could see that the results had become worse for the month of May, with compliance between 0-86%, but were then between 87-99% for the months of June, July and August 2018.

Following our inspection, we received data from the trust in relation to episodes of clostridium difficile and methicillin resistant staphylococcus aureus contracted within the department during a twelve-month period. The timescale used for the information was November 2017 – October 2018 to ensure inclusion of 12 months complete surveillance data. The data showed that during that period there had been three episodes of methicillin resistant staphylococcus identified from blood cultures collected within the emergency department within the specified timeframe, however none of these were identified as being attributable to the emergency department as each patient had shown signs of developing infection/sepsis on presentation to the department, prompting blood culture collection. Each of these instances also met the national definition/algorithm for a community onset infection. Data also showed three episodes of Clostridium difficile infections, which were identified from stool specimens collected within the emergency department within the specified timeframe. However, none of these infections were identified as being attributable to the emergency department as each patient had diarrhoea symptoms on presentation to the department, prompting stool specimen collection and again each of these infections met the national definition/algorithm for a community onset infection.

Any patient presenting with a potentially infectious illness, would be placed in one of the side rooms, until tests had been completed to check if they were infectious and what infection they had, to minimise infection risks.

As the department used material curtains to separate areas and patients, we requested to see the cleaning schedule for the curtains. On receipt of this, it detailed that there was a standard procedure for curtain changes trust-wide, which also applied to the emergency department. This detailed that all curtains should be changed every three months on a periodic register and that all areas could request a curtain change for any curtains that became soiled prior to the routine change schedule, which was available 24 hours a day. For instance, if there had been a patient with an infection such as methicillin resistant staphylococcus aureus, curtains would be changed on the direction of a member of the infection control team, but in the instance of gastrointestinal illnesses, the curtains would be changed once the room had been vacated, as well as the ward receiving a deep clean.

**Environment and equipment**

The service was not always using the environment and equipment in a way which reduced the risks to patients. Some of the areas were tired and worn.

The department could be entered from directly outside the hospital, which led straight into a small waiting area with a reception. The waiting area was small, but during inspection, we were told about the building work scheduled for the department which was due to start very soon after our inspection, which would provide seating for 75 adults and 35 children. Whilst we were on inspection, we were shown the plans for the building work and advised that the new build would
add more spaces within the waiting area, as well as the addition of a separate children’s waiting area, which was much needed.

The entrance inside the hospital was just off the main hospital corridor, which meant that any of the public could come through the department. The unit had been trying to reduce the amount of people coming into the department, but at the time of inspection, the public still had access, which was also where the ambulances waited to hand over their patients, however we were told about the building work which had been approved and was due to start very soon after inspection, which would add more space and help with a better flow through the department.

During inspection, we saw all fire exits to be well-signed with clear exit points and they were not obstructed by any equipment.

There was a new ‘kids zone’ children’s waiting area which was very bright and colourful, full of child friendly pictures and toys, which also had its own separate toilet. The children’s waiting area was situated within the minor’s department and was also at a diagonal to the room used by the department when managing patients with mental health issues. This was not ideal, as any patient within this area could become aggressive or could be shouting and leaving children within the waiting area exposed to any noise, which could lead to distress. Within the majors’ area, children were in bay areas and they could be next to or opposite adult patients, leaving them again potentially exposed to shouting, or other distressing situations.

Staff told us that if the designated mental health assessment room located near to the children’s emergency department waiting area was in use, the bay usually used to treat adolescents would be used to carry out mental health assessments. The department did not have a dedicated 136 suites though it was a designated place of safety under the Mental Health Act 1983. A 136 suite is a place where patients detained under section 136 of the Mental Health Act can be taken and assessed.

The mental health assessment room partially met the basic standards published in the Quality Standards for Liaison Psychiatry Services (2017) by the Psychiatric Liaison Accreditation Network (PLAN). The room was minimally furnished with two doors both of which opened in both directions. They had viewing panels with frosted glass to maintain privacy and confidentiality. The room was clean and plainly decorated with comfortable seating for four people. There was a sign on one door requesting staff not to put non-approved furniture in the room. However, the chairs were worn and could be easily moved meaning there was a risk they could be thrown by a distressed patient. The decoration was tired with scuff marks on walls and the cover on one electric point was partially broken.

Staff told us that the lights had been replaced by two strip lights following the last Care Quality Commission inspection as they had been identified as a ligature risk. The lights were bright could not be dimmed to provide a calm atmosphere. There was a panic alarm and call bell in the room; however, this was not a strip panic alarm as recommended by PLAN.

Staff told us the position of the room between the children’s department and the ambulance arrival corridor meant that the doors were often blocked by trolleys or wheelchairs. However, we did not see this during our inspection and we saw there were signs by the door requesting staff not to block it.

The ambulance hand over area was a very small area off the corridor from the main hospital corridor and we were told this had previously been a storage area. The space had some vital equipment, which we saw to have been correctly PAT tested (portable appliance testing) and a trolley ready for receiving the patients from the ambulance. There was no sink area for hand washing, only one electrical socket and no emergency call bell.
The ambulance hand over area would sometimes have up to three patients on trolleys waiting for treatment, but there was only one curtained area within the hand over bay, which meant that privacy and dignity was difficult to maintain, particularly when there were several ambulance crews waiting to hand over patients and it meant family members were able to hear hand overs regarding other patients. With only having the one hand over area, this also meant that a child could be on a trolley with up to two adults in the small area. On discussing this with senior leaders, we were told that children would be moved from that area as soon as possible.

Two resuscitation trolleys were available within the department, as well as a paediatric resuscitation trolley which was kept in the resuscitation area. The trolleys were sealed with a plastic tab that made it apparent to others if this had been opened. The trolleys and defibrillators were to be checked daily by staff, ensuring the plastic tag was still in-tact and sealed and then a full weekly check of all the contents within the trolley to ensure all equipment necessary was present and in date. There was then a chart that was to be completed and signed on a daily basis once the trolleys had been checked. On reviewing the checklists for one of the trolleys, we found the checklists to be unorganised and it was not easy or clear to see what days had been completed. We found that over the three-month period leading up to inspection, there were 42 days where the one of the trolleys had not been checked and 53 days where the trolley in the emergency assessment unit (EAU) had not been checked.

On examining the contents of the trolleys, we also found some pieces of equipment to be out of date. This included four needles for taking blood samples, a blade used with a laryngoscope, four blood sample bottles and another sample collection tube. One of our specialist advisors also found a laryngoscope loose and not in a sealed packet and this had been found in a trolley noted to be dirty and worn in appearance. After the missed checks had been brought to the attention of one of the senior staff, a further checklist had been developed during inspection. Following inspection, the matron would have oversight of the checklists however, it would be for team leaders to oversee the completion of the required checks.

We were also made aware that there was a shortage of drip stands for intravenous fluids and other intravenous medications and during inspection due to a lack of drip stand availability in the ambulatory majors’ area, the patient had to be transferred to another area of the department as they required intravenous fluids.

Other equipment used such as dressings and syringes were found to be stored appropriately and were all seen to be in date.

Needle sharps bins were stored correctly and none were seen to be overfilled during our inspection.

Within the department, apart from the ambulance hand-over area, there were ample toilets available for use, all with hand washing facilities.

**Assessing and responding to patient risk**

Staff completed risk assessments for each patient and kept clear records, however there were areas in the department where the management of risk needed further improvement.

All patients attending the department took a ticket on arrival and were then reviewed and streamed by the triage nurse, who was a clinically trained member of staff. Details of the presenting problem were taken and then the patient was streamed to the most appropriate place for further treatment and care, which was either to the minors’ area, the ambulatory majors’ area, the Urgent Treatment
Centre (UTC), where a secondary triage nurse completed a more detailed assessment and if required the patient was then seen by the advanced nurse practitioner (ANP), to majors or to the resuscitation area. There was also a separate entrance for ambulance crews to bring patients either to the ambulance hand over area, or straight into resus. Ambulance crews would hand over patients to the time critical nurse who operated from an area off one of the corridors within the department, which had previously been a storage area.

With no emergency call bell in the ambulance hand-over area, we were told that in an emergency, the nurse would shout for help, or would have to leave the patient momentarily whilst help was obtained from the resus area round the nearby corner, or the patient would be pushed round to resus area for assistance and intervention. At night, the nurse overseeing the hand-over area would also be responsible for streaming patients, potentially leaving patients at risk of rapid deterioration in the other area to where the nurse would be.

The emergency department was also co-located with the Urgent Treatment Centre (UTC), which was mainly operated by another provider. The Urgent Treatment Centre mainly accepted referrals from General Practitioners (GPs) and was run by an advanced nurse practitioner and a General Practitioner during the day, with the out of hours General Practitioners covering the service from 5 pm.

Children had vital signs reviewed using the paediatric early warning system (PEWS), which identified children at risk of clinical deterioration. Staff told us that sick children were managed in the majors’ area and that there was always liaison with the children’s unit and they would come to assess and take the child to the ward if required. If a child arrested, someone from the children’s unit would also attend. Following inspection, we requested audits relating to the completion of PEWS within the department, but we were sent some audit information in relation to Modified Early Warning System, which showed that in the month of June 2018, the emergency department was 20% non-compliant with ensuring that patient details, such as name and date of birth were visible on charts, we did not receive any information in relation to the audit of PEWS specifically.

We attended a morning hand over within the department, as part of our inspection. There was a general hand over to all the staff present on that shift and then the team leader handed over to the next team leader and a more in-depth hand over of patients was given. During hand over, it became apparent that a patient had been identified as being at risk of falls, but on asking there had been no formal falls risk assessment completed on them. Staff told us that this would only be done if the patient had attended the department with a history of falls and was over the age of 65 years of age, or if they would be staying in the department longer than 24 hours. We were told about three incidents of falls that occurred within the department; sadly one of those patients had died.

Within the emergency multidisciplinary unit (EMU), there was a rapid assessment team that would assess the risk of falls through assessment and patients with a history of two or three falls were referred to a falls clinic, where there was a more in-depth review of the individual and things that could be causing the falls, such as polypharmacy (the use of multiple medications by a patient), neuropathy and incorrect or ill-fitting footwear. However, during a hand over in the main area of the department, we heard reference to a patient who had been unstable, so needed watching closely. On asking if a falls risk assessment had been completed, staff told us that they would not routinely complete this, unless the patient had presented with a history of falls or was being admitted.

Daily handovers took place at 8am and 8pm, with capacity meetings held at 8.30am, 12.30pm and 5.30pm, when capacity and flow through the department was reviewed, as well as staffing levels.
With sepsis, staff told us that there had been a lot of work completed around sepsis and that there was a trust-wide commitment around sepsis. The trust had a new sepsis pathway and escalation policy and staff we spoke to were proud of this, as there had been a lot of work completed, as this was also one of their Commissioning for Quality and Innovation (CQUIN) targets. A stakeholder engagement event had taken place in September 2017, along with Public Health England, a new quality improvement programme had been initiated and the sepsis steering group re-established. The adapted pathway had been being tested in the emergency department, as well as in the medical assessment unit, with a view to it being rolled out across the trust.

We saw that trust pathways for sepsis in children (dependent on age) were used within the emergency department and staff told us that a nearby children’s hospital had come to meet with staff from the trust to offer some advice based on work they had done in relation to temperatures and the ‘track and trigger’ tool. Following inspection, we had sight of all three of these pathways. Staff told us that sepsis boxes were on order and there was a plan in place for the implementation of ‘News 2’ (National Early Warning Scores). It had been reported to us that compliance figures had starting to rise, since the work had been done. We had sight of the sepsis screening tool used within the department with the sepsis six pathway to be used for adults and young people over the age of 12 with suspected or confirmed red flag sepsis. We saw evidence of NEWS scores being completed appropriately and the necessary responses to high scores.

Training on sepsis was also part of the local induction for new staff and all other staff were trained when the sepsis pathway was launched, as well as staff receiving regular updates at other available training sessions.

Staff referred patients experiencing issues relating to mental ill health to the psychiatry liaison team for a mental health assessment. This was available Monday to Friday 8am to 8.30pm. Out of hours and at weekends staff could request assessments from the crisis resolution team via bleep. Psychiatry liaison and crisis resolution services were provided by a local mental health trust. The psychiatry liaison service provided consultant psychiatrist cover for adults for 2.5 days each week and for older age for 2.5 days each week.

Staff referred patients to the psychiatry liaison team using a mental health and self-harm pathway referral form. The form required staff to carry out a basic risk assessment and provide background information on the reasons for requesting a mental health assessment. Staff we spoke to in the psychiatry liaison team told us this had been introduced in July 2018 following learning from a death from suicide. They felt that they had not been given information that would have aided their mental health assessment of a patient who subsequently took his own life so had introduced the referral form.

The psychiatry liaison and crisis resolution services did not assess patients under the Mental Health Act 1983 (MHA). Staff referred all patients requiring an assessment under the MHA to the relevant local authority. Staff we spoke to told us the local authority responded quickly, however there were issues with the timeliness of response when this was not the nearest local authority or a Welsh local authority.

Staff we spoke with confirmed that the mental health assessment room was used to carry out assessments only, then the patient would return to a bay or room if remaining in the department. They stated that the patient would be medically optimised before any mental health assessment was carried out.

Staff in the psychiatry liaison team told us they often carried out assessments in rooms other than the designated mental health assessment room. They told us they were concerned that other
areas of the department did not meet the required standards for mental health assessment rooms as they were not ligature free and equipped with panic alarms.

Managers told us that patients assessed with mental health problems who remained in the department were placed in bays with open curtains in majors or resus to enable constant observation. They told us they removed any piping or stands to make it as ligature free as possible and would ask security to supervise a patient if they had concerns. However, the bays were not risk assessed and were not ligature free as they were not fitted with collapsible curtain rails.

Security staff were present in the department at varying times to ensure that there were no issues, or threats to patients and carers, staff members, or other members of the public.

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all five questions in the Emergency department survey 2018 relating to the safe domain.

<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 ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

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

In August 2017 the median time to initial assessment was reported to be 321 minutes at the trust compared to the England average of seven minutes. The trust then did not provide data for the rest of the period from September 2017 to July 2018, however the long median in August 2017 and the lack of data in the other months suggest a problem with the trust’s data submission.

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

**Countess of Chester Hospital Chester Cheshire**

The monthly percentage of ambulance journeys with turnaround times over 30 minutes at Countess of Chester Hospital from September 2017 to August 2018 are shown in the charts below.

The percentage of ambulance journeys with turnaround times over 30 minutes peaked in December 2018. This was followed by a downward trend for the rest of the period. Following inspection, we received further information from the trust to suggest that there had been significant improvements made in relation to ambulance turnaround times.
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 July 2017 to June 2018 the trust reported 716 “black breaches”, with a peak of 135 breaches in December 2017.

During inspection we spoke to several paramedics attending and waiting in the ambulance handover area. Some of the ambulance crews told us that they had waited up to three hours to hand over patients in the past, however a lot of them also told us that since the ambulance handover area had been implemented, it had been a positive improvement. Staff at the hospital also told us that they had no ambulance liaison officer.

The trust did not have their own ambulance liaison officer in place in the department. The role of which is to take the hand-over from the ambulance crew and then carry out physical observations and continuation of the monitoring of the patient, until a bed becomes available and to act as a liaison between the ambulance service and the nurse in charge. We were told that the ambulance liaison was based at within a hospital on the Wirral, but that there were weekly discussions with the local ambulance service Operations Manager to discuss handovers and ambulance performance. There had also been ad-hoc meetings with the Operations Manager from North Wales, as many of their ambulances also attended the department.
Nurse staffing

The service had enough staff with the right qualifications, skills and experience to keep adults safe and to provide the right care and treatment, however the department only had three registered children’s nurses.

The 2018 Royal College of Paediatrics and Child Health (RCPCH) ‘Facing the Future-Standards for Children and Young People in Emergency Care Settings’ states that every emergency department treating children must be staffed with two registered children’s nurses. At the Countess of Chester, there were only three registered children’s nurses for the whole department, so they were unable to meet the standard, as this service operated 24 hours a day, seven days a week.

We were told that there was a minimum of two emergency nurse practitioners, with a maximum of three per shift and that they completed 12-hour shifts. The emergency nurse practitioners had their own separate rota.

The department had an advanced nurse practitioner in the majors’ area and one for the clinical streaming area, but these staff members were part of the medical rota.

Planned vs actual

The Countess of Chester Hospital

The trust has reported their staffing numbers for nursing staff within urgent and emergency care at The Countess of Chester Hospital below for the period April to June 2018.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Actual staff (WTE)</th>
<th>Planned staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Emergency Department</td>
<td>68.3</td>
<td>68.0</td>
<td>100.4%</td>
</tr>
<tr>
<td>Ambulatory Care Department</td>
<td>5.0</td>
<td>5.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Emergency Medical Department</td>
<td>3.8</td>
<td>3.8</td>
<td>100.0%</td>
</tr>
<tr>
<td>GP Assessment Unit</td>
<td>2.9</td>
<td>2.9</td>
<td>100.0%</td>
</tr>
<tr>
<td>Urgent and emergency care total</td>
<td>80.0</td>
<td>79.7</td>
<td>100.4%</td>
</tr>
</tbody>
</table>
One of the four departments were reported to be slightly over-established.

During inspection, we reviewed four weeks of off-duty to review the planned versus actual staffing numbers. Senior staff told us that the required numbers were 11 trained and four untrained for the early and late shift and 10 trained and two untrained for the night shift. On review of the off duty over the four weeks, we found that four early shifts, seven late shifts and 10-night shifts fell short of the required staff numbers. There were a few other dates when the early shift fell short, however the advanced nurse practitioners who were streaming worked from 9am until 6pm Monday to Friday so they were counted in the numbers for that shift.

We were told that when there were shortages that were not filled, it would be risk assessed and staffing numbers would be escalated accordingly, and this was also raised at the capacity meeting which was held every morning at 8.30am Monday to Friday. Weekend staffing would also be reviewed as part of this meeting. We were told that a band seven ward manager would work on the weekends to help address any issues. Staff told us of a staffing meeting which also took place every Wednesday, where all wards and areas attended, so any issues could also be highlighted at that meeting.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a vacancy rate of 3.6% for nursing staff in urgent and emergency care at The Countess of Chester Hospital. The trust reported no vacancy target.

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

Turnover rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a turnover rate of 12.3% for nursing staff in urgent and emergency care at The Countess of Chester Hospital; this was higher than the trust target of 10%.

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

Sickness rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a sickness rate of 4.9% for nursing staff in urgent and emergency care at The Countess of Chester Hospital; this was higher than the trust target of 3.65%.

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

Bank and agency staff usage

The Countess of Chester Hospital
We were told on inspection that there were a couple of regular bank staff, but sometimes they would use other bank staff, as well as offering regular staff overtime. Sometimes staff from other areas in the hospital, such as critical care would also help if there were shortages.

The table below shows the numbers and percentages of hours in urgent and emergency care at The Countess of Chester Hospital from July 2017 to June 2018 that were covered by qualified nursing bank and agency staff or left unfilled by department.

Of the 30,687 total working hours available, 16.3% were filled by bank staff and 5.7% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, 9.3% of the available hours were unable to be filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward / unit name</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>Not filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>27,322</td>
<td>4,874</td>
<td>17.8%</td>
<td>1,498</td>
</tr>
<tr>
<td>GP Assessment Unit ANP</td>
<td>2,465</td>
<td>82</td>
<td>3.3%</td>
<td>250</td>
</tr>
<tr>
<td>GP Assessment Unit</td>
<td>900</td>
<td>35</td>
<td>3.8%</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>30,687</td>
<td>4,991</td>
<td>16.3%</td>
<td>1,754</td>
</tr>
</tbody>
</table>

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

**Medical staffing**

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The department had sufficient numbers of consultants in post to meet the requirement of the 16-hour consultant cover seven days a week, between 8am and midnight.

The department had lower numbers of middle grade doctors, which was a national issue. Speaking to one of the senior middle grade doctors, we were told that sometimes they needed to use locum doctors to fill any gaps. The consultants we spoke to also said that it was a nine-person rota however they were not fully established, as the current establishment was five trust appointed doctors and four deaneries appointed (FY1 / 2). Staff said it was difficult to get the full establishment of four doctors from the deanery and currently they only had 2.6 whole time equivalent. Other medical staff felt the quality of the locums was good, as they were mostly long-term locum doctors.

We were told that the times they started would vary and it was staggered to allow for appropriate cover. Within the team, there was a TARN (trauma audit and research network) lead, an ultrasound lead and one undergraduate training specialist.

We were told that there were eight consultants for the department, with again some locum use, but that the department needed 12 consultants, as opposed to eight (due to increased footfall / being a busier department). The consultants we spoke to told us that they had been given assurance / approval from finance leads that they could recruit to increase numbers to 12 consultants by 2020.
Medical staff we spoke to told us that there was an on-call rota and that for weekdays they operated a 1:8 rota (Monday to Thursday) and 1:8 Friday to Sunday weekend on-call rota. We were told that the rota was fully staffed and there were no issues with on-call cover arrangements.

**Planned vs actual**

**The Countess of Chester Hospital**

The trust has reported their staffing numbers for medical staff within urgent and emergency care at The Countess of Chester Hospital below for the period April to June 2018.

<table>
<thead>
<tr>
<th>Department</th>
<th>Actual staff (WTE)</th>
<th>Planned staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medical department</td>
<td>22.0</td>
<td>23.0</td>
<td>95.7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

**The Countess of Chester Hospital**

From July 2017 to June 2018, the trust reported that medical staff had a vacancy rate of 7.2% for medical staff in urgent and emergency care at The Countess of Chester Hospital. The trust reported no vacancy target.

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

**Turnover rates**

The provider supplied us with information to say that between October 2017 and September 2018, the turnover rate for medical and dental staff across the trust was 9.41% (excluding temporary staff).

**The Countess of Chester Hospital**

From July 2017 to June 2018, the trust reported a turnover rate of 48.4% for medical staff in urgent and emergency care at The Countess of Chester Hospital; this was higher than the trust target of 10%. The trust has specifically stated that trainee grades are not included in this figure.

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

**Sickness rates**

**The Countess of Chester Hospital**

From July 2017 to June 2018, the trust reported a sickness rate of 4.6% for medical staff in urgent and emergency care at The Countess of Chester Hospital; this was higher than the trust target of 3.65%.

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

**Bank and locum staff usage**

**The Countess of Chester Hospital**

We have been unable to calculate bank and agency usage as a proportion of the total number of
shifts available because the total shifts available provided by the trust does not include permanent staff.

The table below shows the numbers of hours in urgent and emergency care at The Countess of Chester Hospital from July 2017 to June 2018 that were covered by medical bank and locum staff or left unfilled, broken down by department.

In total, 7,585 hours were filled by bank staff and 11,625 hours were covered by agency staff to cover sickness, absence or vacancy for medical staff.

In the same period, 1,224 hours were unable to be filled by either bank or locum staff.

<table>
<thead>
<tr>
<th>Ward / unit name</th>
<th>Number of bank hours</th>
<th>Number of locum hours</th>
<th>Number of unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and emergency department</td>
<td>6,998</td>
<td>11,457</td>
<td>1,224</td>
</tr>
<tr>
<td>Urgent treatment centre</td>
<td>587</td>
<td>168</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,585</strong></td>
<td><strong>11,625</strong></td>
<td><strong>1,224</strong></td>
</tr>
</tbody>
</table>

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

### Staffing skill mix

In June 2018, the proportion of consultant staff reported to be working at the trust was like the England average and the proportion of junior (foundation year 1-2) staff was lower.

**Staffing skill mix for the 27-whole time equivalent staff working in urgent and emergency care at Countess of Chester 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>29%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>37%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>23%</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 were told that there was depletion in middle grade staff within the department.

**Records**
Staff kept records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Staff kept records of patient’s care and treatment. The department used paper observation charts and then there were separate electronic records for documenting assessments and plans of care, which were used by both nursing and medical staff, as well as other multi-disciplinary staff. When a patient left the department to go to another ward, the paper observation charts would go with the patient to the ward and the staff from the ward would also be able to access the electronic records. Included in the paper charts were pain scores, nausea/vomiting record, record of allergies, sepsis screening tool, blood glucose monitoring, comfort check notes (checking on fluids in and out), drinks and food, medications and physical observations.

The paper observation charts were kept in a clear pocket in a wooden divider on the nurses’ station. These were in use all the time, so were not in a locked trolley, but there were always staff at the nurse’s station.

The records were multi-disciplinary so each professional could see what input others had given to the patient.

We reviewed a total of 15 sets of records during our inspection and we found these to be contemporaneous and comprehensive. We found records were completed, with NEWS, PEWS and pain scores being recorded appropriately.

Staff in the psychiatry liaison team could access the electronic patient record system. They recorded the outcome of mental health assessments and basic care plans on the self-harm and mental health pathway form. Staff told us that if appropriate, the full mental health assessment and crisis plan would also be shared with staff in the department and we saw this in three of five patient care records we reviewed.

We reviewed a further five patient care records for patients referred for a mental health assessment. We saw these were comprehensive with time of arrival in department recorded and time of referral for mental health assessment. All contained a flag that alerted staff to the fact this patient had a mental health issue and the mental health diagnosis was recorded. In four of five records there was evidence of a physical health examination and observations, one patient left the department before this could be completed.

There was a flagging system used on the computer system to identify any children with safeguarding needs and all staff we spoke to were aware of this.

**Medicines**

The service followed best practice when giving and recording medicines, however there were issues with the safe and effective storage and prescribing of medicines that needed further improvement.

During inspection, we checked the recording of the fridge temperatures, as some medications were stored in a fridge and the temperature should range between two and eight degrees and this should be checked daily, with actions taken if the temperature is found to be out of range.

The trust policy stated that fridge readings must be taken daily using a maximum – minimum thermometer in accordance with the manufacturer’s instructions and that the reading must be recorded. The policy also says that the ward manager/senior nursing staff should review the temperature record chart as part of their daily checks.
We checked all the dates over a three-month period and found evidence of 82 days when temperatures were not recorded from the 1 July 2018 to 14 November 2018. During July and August 2018, seven were recorded over eight degrees and a new fridge was obtained. This was discussed with a senior staff member and we were told that all the vaccines had been held in a different fridge, whilst waiting for the new fridge to arrive. There was no input from medicines management team around the use of the vaccines after the increase in temperature and the suitability of their continued use. Trust procedure indicates that staff need to either speak to the medicines information pharmacist or director with the manufacturer.

Within the medicine cupboard in the treatment bay, we found some medicine which had been labelled with ‘once opened use within two months of opening’, however there was no opening date on the label. This medicine was then disposed of by a staff nurse and our pharmacy inspector then discussed cascading the information to other practitioners.

The medicine cupboard in a side room contained four types of medicines, including adrenaline injections which had varying dates of expiry on them, ranging from July 2015 to March 2017. We found that there was no pharmacy input in the minor’s area of the unit, other than to top up Omnicell’s. Omnicell’s are an automated storage and dispensing system for staff to access medications and are often used in emergency departments. Our pharmacy inspector also found that a door marked to store and filled with paper work, including spare prescription charts had been left open.

Within the clean utility room, there was an Omnicell cupboard and fridge and staff had to use a swipe card to access the room. We were told that all staff have swipe access, inclusive of housekeeping staff. We found that intravenous solutions were stored in open baskets in a long cupboard in the room, which were also accessible to non-qualified staff. On our first day of inspection, on finding that fridge temperatures were not always checked daily, we asked if there was a pathway for staff to follow if the temperature was found to be out of range. We were told by the matron that there should be, but one was not present at the time of asking. This was rectified during inspection and when our pharmacy inspector checked, this was displayed on the wall detailing action to be taken if the fridge temperature was found out of range. Our pharmacy inspector checked the fridge temperatures in the clean utility and found that between August 2018 up to the time of inspection, the fridge had not been checked on 50 occasions. The temperature had also gone above the required eight degrees on a total of 31 times. During the 31 times the temperature had gone out of range, there was only one occasion when it was recorded that any action had been taken.

It was also noted that there was no ambient room temperature monitoring in that room. We found that for controlled drugs, there were four record books for staff to monitor and record. The contents were checked against the record and quantities matched what was recorded in the book and all were inside their expiry date.

Within the resus room, keys for all cupboards were held by qualified members of staff and in the adult medicine cupboard all the medicines checked were within expiry date, as were all the medicines contained in the fridge. Monitoring of the fridge temperature was a single point temperature and not minimum/maximum temperatures. These were recorded on the resus checklist, which was completed on the night shift. It was not the trust temperature monitoring document and had no area for recording actions because of temperature issues. The paediatric medicine cupboard contained medicines which were within their expiry dates on checking. There was a paediatric intravenous folder on the shelf, but it was unclear where the information had been obtained from.
During our inspection we looked at prescription charts and we found emergency admission charts with medicines appropriately prescribed on the bottom of the rear page. The prescriptions seen were signed and dated by the prescribers, they were legible and the administration box had been completed for each medicine administered. Allergies had been recorded on the patient’s stick on label on the front of the form, along with patient’s date of birth.

We saw that there was a stock medicine cupboard and bedside lockers for most patient’s beds. We found one locker that had a broken lock and so staff kept the medicines in the bottom of the medicine cupboard. On inspection we found five patient’s named medicines in the top drawer of the cupboard, but the patients were not on the ward. We also found one patient’s own medicine in one of the stock drawers among the stock medicines and again the patient was not on the ward. There were eight strips of medicines out of their boxes in the stock cupboard including pregabalin and gabapentin. On discussion with the nursing assistant, they indicated that the patient’s own medicine was removed from the cupboard on an ad-hoc basis by the staff and placed in the disposal bins in the clean utility room. The staff nurse was not usually on the ward and was unaware of this procedure. We checked 10 medicines in cupboard and all were within their expiry dates.

On discussion with one of the medical staff, we asked if oxygen was always prescribed. We were told that best practice would be to prescribe oxygen, however on looking at a medicine chart for a patient within the resuscitation area who was on nasal oxygen, the oxygen had not been prescribed.

**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.

The trust used an electronic incident reporting system. Staff were aware of how to complete this and they knew that they could press a button to request an outcome of the incident being reviewed. Staff knew when and what types of incident needed to be reported.

During inspection, we saw evidence of Duty of Candour being completed, in relation to three complaints that had been made. Duty of Candour is whereby all healthcare professionals must be open and honest with patients when something goes wrong. In the first instance, there would be an apology to the patient and family/carer and if the harm had been moderate or serious, a letter would be written to the patient letting them know about the investigation.

We saw that the trends for incidents between the month of May and October 2018, included: medication, equipment, staffing, medication, treatment, bed management and staffing.

Following inspection, we had sight of the investigations that had been completed into three of the incidents we had reviewed during our time in the department. These set out the background information, initial findings, details of the incident and any learning or changes to be made because of the incident.

**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
From October 2017 to September 2018, the trust reported no incidents which were classified as never events for urgent and emergency care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from October 2017 to September 2018. A breakdown of the incident types reported is in the table below. The incident pending review related to waiting times in the emergency department.

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>4</td>
<td>36.4%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>2</td>
<td>18.2%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>2</td>
<td>18.2%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>2</td>
<td>18.2%</td>
</tr>
<tr>
<td>Pending review</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

We discussed some of the falls in depth with the one of the matrons for the department and examined actions that were taken and any learning taken from the event.

Safety Thermometer

The service used safety monitoring results well.

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, no falls with harm and no new urinary tract infections in patients with a catheter from August 2017 to August 2018 within urgent and emergency care. However, we were told of three falls that had occurred within the department, with one patient dying.

Following inspection, we requested more data from the trust in relation to more recent figures, which we did receive. For the months of August, September and October 2018, the data rate free of new harms was higher than the national average.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The urgent and emergency care services department used pathways that were evidence based in line with the National Institute for Health and Care Excellence guidelines and the Royal College of Emergency Medicine’s clinical standards for emergency departments.

The policies were available on the trust intranet and all staff had access to this. One of the policies we saw was for physical intervention, control and restraint, with a date of 1 August 2016. It was not clear when this was due for renewal. The policies were available on the trust intranet and all staff had access to this. One of the policies we saw was for physical intervention, control and restraint, with a date of 1 August 2016. It was not clear when this was due for renewal. Following inspection, the trust advised us that the policies were reviewed every three years, although this was not evident when looking at this particular policy at the time of inspection.

The department participated in the Royal College of Emergency Medicine audits and some of those included: Moderate and acute severe asthma, Consultant sign off and severe sepsis and septic shock 2016/17. The Royal College of Emergency Medicine has been auditing against some key standards for many years, to assist Emergency departments in improving their quality of care.

Nutrition and hydration

Staff gave patients food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

Within the waiting room, we saw a vending machine for drinks and snacks and we were also aware of coffee shops and a restaurant available in the main hospital for relatives/carers and the public to access.

In the majors’ area, we saw a trolley with cups and jugs of water and a sign indicating that people could help themselves to this.

Health Care Assistants completed ‘comfort and care’ assessments to review fluid intake and output.

We were told that there had been no housekeeper in the department for ten years. We were told that the department had access to a selection of snacks for those who needed them.

In the Emergency Multi-Disciplinary Unit, we saw a coffee machine, with lots of cups and various drinks available for patients and relatives/carers to use freely.

During the inspection period, we saw a lot of ambulance crew waiting to hand over patients one evening. On speaking to ambulance staff we asked if their patients would be offered a drink by hospital staff whilst waiting for up to long periods on the trolleys and we were told that it would be the crew who would attend to getting a patient a drink if they needed one. However, we were also told that sometimes it would not be appropriate for a patient to have a drink until they had been assessed regarding their presenting condition.
Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.6 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 (October 2016 to March 2017; published October 2017)

Pain relief

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

The Trust had a guideline on the Trust document library entitled: ‘Guideline to pain assessment’, which we had sight of following inspection. The guidelines offered staff information and advice in relation to assessing pain levels in adult, non-verbalising adults and children using different tools.

The pain score used within the department for adults was a nationally recognised pain score within the National Early Warning Scores (NEWS) (2) chart 0 – 3.

In the management of non-communicative patients, we were told that the National Early Warning Scores (2) chart advised to use the Abbey Pain Tool. This tool had six questions to assess people in pain with dementia who could not verbalise, with each question having a possible three scores dependent on how the patient was presenting at the time of assessment.

The pain score tool used with paediatric patients was the Wong Baker assessment with the utilisation of Smiley faces, based on six different faces, scoring from 0-10 and then the faces, legs, activities, cry and consolability (FLACC), which scores between 0-2, dependent on the reaction to each of the category detailed.

During a review of records and charts used within the department, we did see evidence of the pain scores being appropriately completed for patients on a regular basis.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.6 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 7.2 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 (October 2016 to March 2017; published October 2017)

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The Royal College of Emergency Medicine (RCEM) have been auditing against key standards to assist UK emergency departments to improve in their quality of care. The service participated in the Royal College of Emergency Medicine (RCEM) audits between 2016-2017 and achieved variable results. However, for the Royal College of Emergency Medicine Audits 2016/17 in:
moderate and acute severe asthma, consultant sign off and severe sepsis and septic shock, the department failed to meet any of the national standards.

The data we were given only relates to the 2016/17 audits, so we are unable to advise as to whether these audits have since improved or deteriorated.

**RCEM Audit: Moderate and acute severe asthma 2016/17**

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, The Countess of Chester Hospital emergency department failed to meet any of the national standards’ targets of 100%. Trusts are all assessed and compared together. The lower quartile means that a trust is performing in the lowest 25% of trusts nationally against a standard. The upper quartile means that a trust is performing in the top 25% of trusts nationally against a standard.

The department was in the upper UK quartile for two standards:

- **Standard 2a (fundamental):** As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 42.0%; UK: 26%.

- **Standard 5b:** If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

- **Standard 5b (fundamental):** within 4 hours (moderate). This department: 47.1%; UK: 28%.

The department was in the lower UK quartile for one standard:

- **Standard 3 (fundamental):** High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 2.0%; UK: 25%.

The department’s results for the remaining four standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

One member of the medical staff that we spoke to felt severe asthma was managed well within the department and there was a clear escalation pathway in place which staff were familiar with and adhered to accordingly.

With regard to this RCEM audit, we were told that the department had scored low for not having written discharge materials, discharge leaflets, which were under development and to be in place by the end of 2018. The department had also been developing a discharge plan document with a written asthma plan to give to the patient when they were discharged, to enable the patient to take this plan to their own General Practitioner to discuss further treatment. We were also told that the department had scored low for standard five (nebulise within 10 minutes), as most patients came to hospital with a pre-hospital nebuliser from the ambulance crew, which resulted in a low score in the audit.
RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, The Countess of Chester Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for one standard:

Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 20.0%; England: 11%.

The department’s results for the remaining two standards were within the middle 50% of results.

Data for standard 3 (consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge) was not reported by the trust.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, The Countess of Chester Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for three standards:

- 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. This department: 92.0%; UK: 69.1%.

- Standard 4: Serum lactate measured within one hour of arrival. This department: 84.0%; UK: 60.0%.

- Standard 5: Blood cultures obtained within one hour of arrival. This department: 92.0%; UK: 44.9%.

The department’s results for the remaining five standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

Staff told us that they felt there were clear pathways in place for adults and children and that sepsis was well-managed, but to improve on the standard antibiotic within one hour, the department had started to use pre-prepared antibiotic medicines to reduce delays in treatment.

As the 2017/18 audit data had only been published a few weeks before inspection, this was not reported on in this report.

During inspection, one of our inspectors spoke with the TARN (trauma audit and research network) audit lead, who told us that there was a trauma audit and research network dashboard in place and that the department had both a lead consultant and dedicated trauma nurse and that the department was over-performing in data collection. We were told that the time to CT scan had improved because the attending doctor had been able to request the CT scan directly
from the radiologist, but previously this could only have been done by a senior doctor.

**Unplanned re-attendance rate within seven days**

In August 2017 and from October to July 2018 the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and better than the England average in every month with the exception of May 2018 when 7.9% of patients both at the trust at nationally had an unplanned reattendance within seven days. The trust provided no data for this indicator in September 2017.

**Unplanned re-attendance rate within seven days - Countess of Chester Hospital NHS Foundation Trust**

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

**Competent staff**

The service tried to ensure staff were competent for their roles, although managers were not always able to appraise staff’s work performance and hold supervision meetings with them in the required time frames.

There were not enough registered children’s nurses within the department, as there were only three registered children’s nurses in the department. Guidance indicates that every emergency department treating children must be staffed with two registered children's nurses. This was raised as a concern with the trust.

Staff within the department had varying qualifications and experience. The department had a mix of advanced nurse practitioners, and three emergency nurse practitioners, all of which operated at a senior level, possessing key skills and knowledge. We were also told that there was an additional two members of staff undertaking the emergency nurse practitioner course. The specialist skills of the advanced nurse practitioner enabled them to work at a similar level to the doctors and they were part of the medical rota. The emergency nurse practitioners also took on other roles within the department, managing staff sickness, the e-rostering, induction and the management of the health care assistants.

Senior leaders told us that there were four places for staff to attend the paediatric advanced life support training each year and four for paediatric immediate life support and staff would be assigned to these places accordingly. We were told that within the department there were six trained nurses with paediatric advanced life support, a total of 26 staff (nursing and medical) with
paediatric immediate life support, 30 staff members with intermediate life support and three with advanced life support. There was also a consultant available from 9am until midnight who was trained in paediatric advanced life support.

A large majority of the staff within the department had undergone further training. We were told that five staff had attended a full day training on paediatric illness at a local university, one senior nurse had undertaken a six-month module in paediatric injuries and illness. We were also told that one of the registered children’s nurses from the ward had delivered a paediatric study day in June 2018, in which five nurses attended. Some staff had also attended the Aintree Trauma Centre Study Days, which had offered two different levels of training.

We saw evidence of 31 staff members having completed the Acute Life-Threatening Events Recognition and Treatment training, which was an eight-hour training course designed to enable healthcare practitioners with a structured system to assess, recognise, manage and escalate the care of a deteriorating patient early to prevent further clinical deterioration.

Incident training was performed monthly in the department, with medical and nursing staff in attendance and any students were also invited. The training would involve a given Scenario, encouraging all staff to think and act quickly, but within a controlled situation to prepare staff for any eventuality that potentially occur at any point within the department. Some of the topics that had been covered had been chest trauma, pacing and serotonin syndrome.

Further training was offered to staff within a ‘breakfast club’ and this offered training on different topics daily, with topics including: burns, hypoglycaemia, splints, stroke, mental capacity, insulin safety, palliative care, asthma, self-harm to mention only a few. Two sessions would operate, enabling night staff to also access any training.

The induction package for new starters included staff attending the children’s ward for an afternoon to observe the management of illness in paediatrics.

We were told that there was a training development system in place and that junior and middle grade medical staff had a weekly training session and that consultants would cover for these staff whilst they attended. However, it was sometimes difficult for consultants to get away for training sessions if the department was very busy. We did not see evidence of training systems specifically for medical staff during inspection, although we did see programmes of training sessions which were delivered regularly and open for all staff members to attend.

During the inspection, we spoke to three students, who were all nursing students. They reported to have been welcomed onto the unit by staff and had felt that they had been fully supported with achieving their learning needs and had thoroughly enjoyed their placements. We also saw other students attending the department, being supported by staff during a transfer of a very sick patient to the resuscitation area.

The department also had two student physician associates, who could review patients and book diagnostic tests such as x-rays, but they were unable to prescribe medicines.

The target compliance rate for staff appraisals for the trust was 95%. We do not have current figures and the figures below include health visitors, which are not part of the nursing team within the emergency department.

**Appraisal rates**

**The Countess of Chester Hospital**

From April to June 2018, 81.3% of staff in urgent and emergency care at The Countess of
Chester Hospital received an appraisal compared to the trust target of 95%. A breakdown by staff group is provided below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Qualified nursing and health visiting staff</td>
<td>67</td>
<td>76</td>
<td>88.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>14</td>
<td>19</td>
<td>73.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medical and Dental staff - Hospital</td>
<td>10</td>
<td>16</td>
<td>62.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
<td>112</td>
<td>81.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust’s appraisal target was met by none of the four staff groups within urgent and emergency care shown above, however it should be noted that the data only covers a three-month period. Qualified nursing and health visiting staff achieved an appraisal completion rate of 88.2% and medical staff achieved an appraisal rate of 62.5%.

(Source: Routine Provider Information Request – Appraisals tab)

One member of staff we spoke to on inspection reported to have never had an appraisal.

**Multidisciplinary working**

There was an effective multidisciplinary team working environment within the service, particularly within the emergency multi-disciplinary unit, which operated Monday to Friday 9am until 5pm. All patients that passed through this area were reviewed by a junior doctor, geriatrician and an occupational therapist. There was also a rapid assessment team that worked closely with the unit that comprised of an occupational therapist, physiotherapist and a social worker, who all worked together to ensure the patients had all their needs met.

Handovers occurred twice a day at 8am and 8pm and this involved a hand over to the all the nursing staff, which was led by the team leader for the shift that had just occurred and detailed which area each staff member would be working. After hand over, the nurses would receive a more detailed hand over of their patients in the area they were working in.

Physiotherapists also ran a falls clinic for patients who had presented with a history of repeated episodes of falling.

There was effective multidisciplinary working with the mental health services team.

We were also told about other times when there was effective multi-disciplinary working, particularly in relation to the Hospital Alcohol Liaison Service team.

**Seven-day services**

The Urgent and Emergency Care department within the hospital operated 24 hours a day, seven days a week.

The department could access mental health services for patients requiring a mental health assessment 24-hours a day seven-days a week from a local mental health trust. A psychiatry liaison service was based in the department Monday to Friday 8am to 8.30pm. Out of hours and at weekends the department could access mental health crisis resolution services via a bleep. Staff
told us that during core hours mental health services responded to requests for mental health assessments in a timely manner. However, the reported that out of hours patients could wait up to six hours for mental health assessments. We reviewed five patient care records and saw that patients referred for mental health assessments waited between two and six hours for assessment.

The Rapid Response Team consisting of an Occupational Therapist and Physiotherapist operated seven days a week, with Physiotherapy clinics also held during the week.

The Hospital Alcohol Liaison Service were available five days a week, offering interventions to people with alcohol related conditions presenting at the hospital. The unit also referred into a local support team, working with people with either drug, or alcohol misuse, mental illness, or learning disabilities, which took referrals five days a week.

The department also had access to on-call Pharmacists.

There was access to specialists Monday to Friday, inclusive of cardiac specialists, oncology specialists, a diabetes nurse specialist, Macmillan nurses, as well as Dementia nurses and Learning Disability nurses.

Health Promotion

Staff within the department identified and took opportunities to promote health to patients, when appropriate.

We were told that information leaflets and advice could be printed off for patients to take home on specific injuries, or conditions, such as head injuries and that there was also a button on the computer to change the language, making them accessible to none-English patients.

During the time of inspection, we saw specialist nurses running a pressure ulcer awareness day in the main corridor of the hospital for staff, public, patients and carers to access and find out more information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

During the time of inspection, there were no patients in the department with a Deprivation of Liberty Safeguards in place and the last one had been two weeks before our arrival, so we were unable to review this fully during inspection. We did see flow charts on the walls for staff to follow in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards and there was also a reasonable adjustments process for staff to follow.

One of the medical staff we spoke to told us that they were very familiar with mental capacity and the best interests process and could give an example of a patient with dementia that needed treatment and couldn’t consent, so there had been a discussion between the nurse and the next of kin involved in the best interest discussion and told us this had been documented in the records.

Once patients experiencing mental distress had received the necessary medical treatment, staff told us that when possible, the best place for these patients, was for them to be referred to the neighbouring trust, specialising in mental health.
We were told that there was a care pathway for self-harming children under the age of 16 years of age. These young people would then be referred to the Child and Adolescent Mental Health Services once their medical needs had been addressed, the Child and Adolescent Mental Health Services would pick up the referral in the morning. We were told that there was also a health and well-being practitioner who was based within the emergency department.

On speaking to senior staff, we were told that there was no specific training on Gillick Competence/Fraser guidelines and that there was a gap in knowledge within the adult-trained workforce. Gillick competence and Fraser guidelines relate to a child being able to consent to their own treatment and contraceptive advice and treatment being given to children under 16 years of age respectively.

Mental Capacity Act and Deprivation of Liberty training completion

The Countess of Chester Hospital

The trust set a target of 90% for completion of Mental Capacity Act (MCA) training. The trust informed us that this course encompasses deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA training from July 2017 to June 2018 for nursing staff in urgent and emergency care at The Countess of Chester Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
<th></th>
<th></th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>target</td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>76</td>
<td>83</td>
<td>91.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust reported that from July 2017 to June 2018, Mental Capacity Act (MCA) training was successfully completed by 91.6% of nursing staff in urgent and emergency care eligible for the training.

A breakdown of compliance for MCA training from July 2017 to June 2018 for medical staff in urgent and emergency care at The Countess of Chester Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
<th></th>
<th></th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>target</td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>21</td>
<td>25</td>
<td>84.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust reported that from July 2017 to June 2018, Mental Capacity Act (MCA) training was successfully completed by 84.0% of nursing staff in urgent and emergency care eligible for the training.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Is the service caring?

Compassionate care

Throughout our inspection, we saw all staff interacting with patients, carers and family members in a very caring, polite and friendly manner. All the people we spoke with during the inspection were happy with the care and treatment provided by the service.

In all areas of the department that we visited, staff greeted us and all other visitors to the department in a friendly way and we found all staff members regardless of grade or seniority, to be very helpful and accommodating.

During inspection we spoke to eight patients and carers. All of them reported the care to be good and the staff to be very kind and supportive and could not do enough to help. We observed all staff speaking to the patients in an age appropriate way and in a calming manner.

Staff responded compassionately when people needed help. We saw several different members of staff offer sensitivity and a comforting hand to those who needed it and whilst in the resuscitation area, we saw all the staff and students speaking with such care and compassion to the patients and relatives present.

We saw a very young patient given a teddy bear by a member of the security staff who was present in the department at the time, which meant a lot to the young patient.

Staff tried to ensure privacy and dignity were preserved, which was easier in some areas of the department than others.

One patient who felt that had received such compassionate care made a beautiful thankyou card for the team and we saw how grateful and how valued they had been made to feel during their care, whilst reading what they had written.

The unit participated in the NHS Friends and Family Test. The results were worse than England average between August 2017 and July 2018, however, no issues were raised to us during the inspection.

Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average from August 2017 to July 2018, with a decrease in the percentage seen from February to July 2018.
Emotional support

Staff provided emotional support to patients to minimise their distress.

We saw staff involving both patients and parents and carers in their own care, allowing time to answer any questions.

During inspection, we saw children receiving interventions, but on asking there was no dedicated and trained play specialists available to work with children to help in providing emotional support through interventions and treatments. We were told by staff that they would use toys from the children’s waiting area, or they also had small teddy bears they could give to the children to help distract them.

For relatives and carers of those patients who were particularly unwell in the department and for those needing to be told bad news, there was a relative’s room available with comfy seats. In situations where patients were dying, or had died, staff used a butterfly symbol on the entrance to the area, to alert all staff members, so that privacy could be maintained.

We were told that there was chaplaincy support for those who wanted this 24 hours a day from the chaplaincy team, which comprised of chaplains and volunteers of varying religious denominations and beliefs. There was also a bereavement team within the trust that could offer additional emotional support to relatives, carers and staff as required.

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.
All the patients and carers we spoke with during the inspection told us that they were happy with the care and treatment provided by the staff and that everything, including test results had been explained to them in a way that they could understand, which was reflected in the Emergency Department Survey 2016 results as detailed below, where the department scored 8.9, which was like that of other trusts.

Patients and carers, we spoke to said that they had been involved in their plan of care.

We saw family members and carers with their loved ones throughout the department and in the resuscitation area (when this was appropriate), allowing them to be close to those they loved, whilst offering support to those unwell.

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all of the 24 Emergency Department Survey questions relevant to the caring domain.

<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>3.4</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>8.4</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>8.0</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>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.7</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>9.1</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>7.3</td>
<td>About the same as 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>8.7</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>7.8</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>9.1</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>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.1</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>6.5</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>8.4</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>8.5</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>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.9</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>8.9</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>4.8</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>5.2</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 emergency department?</td>
<td>5.1</td>
<td>About the same as other trusts</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>5.6</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>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
Is the service responsive?

**Service delivery to meet the needs of local people**

The service planned and provided care and treatment in a way that met the needs of local people. It worked with local commissioners and other healthcare providers to understand current and future demand.

The urgent and emergency care department was located at the hospital on the Countess of Chester Health park, within easy reach of the motorways and train station and with clear signage from the main roads. There was ample car parking space across different car parks, with clearly marked areas for disabled parking. The hospital was also accessible by different bus routes.

People attended the service primarily from the local area, although the service also received patients from Wales.

The service worked with clinical commissioning groups (CCG), as well as linking in with other hospitals, to build on specific knowledge and to improve services delivered.

In the waiting area there was a vending machine for snacks and drinks, as well as a restaurant on a different floor, so people could get something to eat and drink.

Within the department, there was a children’s waiting area, which had its own toilet contained in the area and there were toys available for young children to play with, as well as a television (although we did not see this switched on whilst we were there). The area was colourful and child friendly in appearance, although this was within the minors’ area and almost opposite the room used for patients attending with mental health issues.

**Meeting people’s individual needs**

In some areas of the department, maintaining privacy and dignity was an issue, particularly in the ambulance hand over bay which only had one internal curtain inside the area, with up to three patients on trolleys in that area at any one time. This meant that when there was more than one patient waiting in the area, any other patients and their carers/relatives could hear confidential information relating to other patients. This was also evident for those waiting on ambulance trolleys, who were also able to hear other hand overs and histories taken on poorly patients. We also observed members of the public and other family members walking down the corridor where the ambulance staff and hand over bay were situated, again being able to see patients on trolleys in corridors and able to hear hand overs.

The department employed a mental health coordinator to work with all patients in the department experiencing mental distress. They had been in post since October 2017. The coordinator was a registered nurse with a background in counselling and was supernumerary. They offered basic emotional and psychological support to all patients in the department in distress. They also delivered mental health awareness training to staff. The coordinator followed up any patients they had contact with by telephone the day after they were discharged. Staff told us they had received positive feedback from patients about this service. However, during our inspection the mental health coordinator was not in work and there was no cover for absence.

For patients attending experiencing mental distress, there was a room used for those on a Section 136 order. A Section 136 is an emergency order to take someone to a place of safety if suffering from a mental illness and in need of immediate care. The furniture in the room was not so solid
that it could not be lifted and thrown by someone displaying agitation or aggression. We were told that the ceiling tiles had been changed since the last inspection to reduce the ligature risks to patients in distress, however we were told that patients were never left on their own in the room and the room was mainly used for the psychiatric liaison team to undertake assessments. There was also another room set up in the same way off the corridor, opposite the ambulance hand over area. This room had two doors, making it easier for someone to escape if they wanted to.

Senior leaders told us about a new complex care team in development, looking would be identifying vulnerable patients with complex needs and the use of a tool to identify patients who would need zoning, if at risk of falls. The team had also been looking at training around challenging behaviours, using the least restrictive practices. Staff told us that when possible, if they were aware of a patient coming into hospital with challenging behaviours, they would try to avoid security having to become involved.

Working in partnership with local Clinical Commissioning Group, the hospital used a ‘red bag passport’ scheme, which enabled patients who lived in a care home within a local area to have standardised papers documenting important information about the patient, along with personal items which follows the individual from admission.

For patients seen by the emergency multidisciplinary unit (EMU), there was a reablement team that would assist in enabling patients to get home in the safest and best possible way for them. These patients would also receive a well-being call to check that the individual was managing. The manager of the unit also told us about the ‘green car service’ which was a paramedic and a therapist (if not on duty) who would attend homes for patients who needed this. This unit also had a dedicated frailty consultant manager who was working alongside Age Concern.

For patients who were hard of hearing or visually impaired, staff told us that they would be able to access headsets and picture boards from nearby specialist wards, to aid with communication if required.

Patients who were none-English speaking could access an interpretation service that the trust used and staff told us that they also had a couple of members of staff within the department who were able to sign to those who might need it.

The trust had therapy dogs who attend the hospital twice a month and visit different areas of the hospital. Therapy dogs are dogs with a clam disposition who can be used in care settings to offer comfort and affection to people.

Patients with learning difficulties could access a quiet area and staff told us that they would always try to ensure that patients with learning difficulties were not left waiting for too long. We were told that there were picture books to help explain treatments and procedures and staff would work closely with carers to ensure the patient’ needs were addressed.

For patients with dementia, we were told that staff could access twiddle mitts for distraction. Twiddle mitts have accessories attached for people to touch and move and this can be a good way of reducing anxiety, whilst promoting a sense of calm. These can be particularly useful for patients with dementia, or also those with learning difficulties.

**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.
Q7. Were you given enough privacy when discussing your condition with the receptionist?  
7.1 About the same as other trusts

Q11. Overall, how long did your visit to the emergency department last?  
6.8 About the same as other trusts

Q20. Were you given enough privacy when being examined or treated?  
8.9 About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Access and flow

The service’s performance against national targets was poor and often below the England average.

One of the areas highlighted in the last CQC report, was that the trust should review processes to improve access and flow through the accident and emergency department. The service had tried to make improvements in relation to this, since we last inspected.

Since the last inspection, there had been the introduction of different areas within the department. This had included the development of the ambulance hand over area and the emergency multidisciplinary unit.

The ambulance hand-over bay was off the main corridor in which the ambulance crews brought the patients into the hospital. Crew we spoke with told us of extremely long waits to hand over patients, but each crew we spoke with did also think the hand-over bay had made a positive difference in reducing the time to hand over patients.

Staff told us that there would frequently be a delay in the handing over of patients from the ambulance hand over bay to the ambulatory majors’ area, as staff were so busy, yet the patients in the hand over area needed to be seen as soon as possible.

The emergency multidisciplinary unit enabled frail patients to receive early identification and if well-enough, they could be moved from the main department to the specialist frailty unit, to ensure they got access to services such as Occupational therapy, Physiotherapy and Social Workers and got home as soon as it was safe and appropriate for them to do so.

There was a new Operations Manager who had only been in post two months at the time of inspection and their role was to oversee and improve the access and flow within the department, especially as the figures for median time from arrival to treatment, percentage of patients admitted, transferred or discharged within four hours and the percentage of patients waiting more than four hours from the decision to admit until being admitted all fell below the England average results.

We were told that there was a capacity meeting held in the department three times a day to review the flow of patients, to try and improve the flow through the department.

Managers told us the service had a Commissioning for Quality and Innovation (CQUIN) target to identify and work with frequent attenders to the department. They had identified 46 frequent attenders, 16 on the first cohort and 30 on the second. The department matron received a report weekly that identified all frequent attenders. They met with local GPs, the ambulance service, a homeless charity, social service and colleagues from a neighbouring mental health trust to coordinate services to the identified frequent attenders. A targeted multidisciplinary team meeting was held for each frequent attender identified and shared care plans developed. Managers told us that since this approach started they had seen five patients attend the department less frequently.
Managers told us they were working with another trust to look at their successful model of working with frequent and attenders and learning from this. Staff gave an example of working successfully with social services, the police and care workers for a frequent attender who had reduced alcohol related attendances at the department.

The department was taking part in a national ‘deep dive’ exercise to look at demand and capacity for treating patients with mental health issues in accident and emergency departments. A deep dive is a quality improvement tool that immerses a group or team into a situation for problem solving or idea creation. As part of this exercise the department had identified all the patients attending in a one-week period and was reviewing the care provided and care records. Managers told us that 61 patients had been identified and they felt this was an average number of patients attending the department with mental health issues in a week.

**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 should be no more than one hour.

The trust did not meet the standard in any month from October 2017 to July 2018 and performance against this standard generally declined over the period. In October 2017 the median time to treatment was 96 minutes compared to the England average of 59 minutes. In comparison, in July 2018, the median time to treatment was 123 minutes compared to the England average of 64 minutes.

The eight minutes from arrival to treatment reported in August 2017 appears to be an error, and no data was provided by the trust for September 2017.

**Median time from arrival to treatment from August 2017 to July 2018 at Countess of Chester Hospital NHS Foundation Trust**

![Graph showing median time from arrival to treatment from August 2017 to July 2018 at Countess of Chester Hospital NHS Foundation Trust](image)

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

**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 emergency department.

From September 2017 to August 2018 the trust failed to meet the standard and performed worse than the England average. Performance generally declined from October 2017 to February 2018 and then improved up to August 2018.
Four-hour target performance - Countess of Chester Hospital NHS Foundation Trust

(Source: NHS England – A&E Waiting times)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From September 2017 to August 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

From September 2017 to February 2018 performance against this metric showed a trend of decline and then fluctuated from March to May 2018, before generally improving again until August 2018.

In March 2018, an incident was logged as 97 patients failed to be discharged from the department within the four-hour target. The incident submission described a range of clinical and operational elements to the day in question. The escalation bleep had to be used in escalation circumstances, however looking at the incident review, it appeared that generally staff had been unsure as to what operational response changes would occur once the bleep had been activated and as its use had become quite normalised, there had been a question around its effectiveness.

Another issue raised was the rostering of clinical staff to match known clinical demand, as this was documented to be misaligned. It was reported that there was inconsistency across the seven days of the week within the medical roster in that staffing supply was not mapped consistently to known demand across the seven-day cycle after allowing for mandatory and highly important educational activity.

On this occasion, it had been highlighted by several nurses and managers that the leadership within the senior clinical team was very variable and that this had an impact upon the operational effectiveness of the department on a given day.
Percentage of patients waiting more than four hours from the decision to admit until being admitted - Countess of Chester Hospital NHS Foundation Trust

The table below shows the monthly numbers of patients waiting more than four hours from the decision to admit to being admitted over this time:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2017</td>
<td>369</td>
</tr>
<tr>
<td>October 2017</td>
<td>430</td>
</tr>
<tr>
<td>November 2017</td>
<td>509</td>
</tr>
<tr>
<td>December 2017</td>
<td>704</td>
</tr>
<tr>
<td>January 2018</td>
<td>658</td>
</tr>
<tr>
<td>February 2018</td>
<td>744</td>
</tr>
<tr>
<td>March 2018</td>
<td>764</td>
</tr>
<tr>
<td>April 2018</td>
<td>662</td>
</tr>
<tr>
<td>May 2018</td>
<td>711</td>
</tr>
<tr>
<td>June 2018</td>
<td>498</td>
</tr>
<tr>
<td>July 2018</td>
<td>536</td>
</tr>
<tr>
<td>August 2018</td>
<td>385</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

Over the 12 months from September 2017 to August 2018, no patients waited more than 12 hours from the decision to admit until being admitted.

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

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

From October 2017 to March 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment fluctuated around the England average.
The trust did not provide data for a number of months over the period from August 2017 to July 2018.

**Percentage of patient that left the trust’s urgent and emergency care services without being seen - Countess of Chester Hospital NHS Foundation Trust**

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

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

In August 2017 and from October 2017 to July 2018 the trust’s monthly median total time in A&E for all patients was higher than the England average. The trust did not provide data on total time in A&E for September 2017.

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

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. Within the trust, there was a Patient Advice and Liaison Service to provide support to patients, carers and families.

Complaints themes were listed on a board within the department. Between the 1 April 2018 and 1 October 2018, the main themes for complaints within the department included: clinical treatment, delayed treatment, attitude and communication.

During inspection we discussed three complaints in depth with one of the senior leaders. The first one was in relation to communication, which came from the Patient Advisory Liaison Service (PALS) and this was a formal complaint. We saw evidence of letters sent in reply to the issues raised by the complainant and statements from staff and actions taken as a result. We saw that this had been addressed fairly and with reason.

The second complaint was about delay in treatment. We saw the audit trail of correspondence used to manage the complaint and saw evidence of the letter sent to the complainant from the trust.

The third and final complaint we reviewed had come through Healthwatch (the independent national champion who focus on the needs and experiences of people using health and social care services). The complaint came from a patient who had a lot of needs and wanted an apology. We saw the thankyou card that had been hand made by the patient, after staff had spent a lot of time speaking with them and explaining care and treatment. The patient was extremely grateful for the input and support they had received.

Throughout all these cases, we saw evidence of Duty of Candour being completed. Duty of Candour is whereby all healthcare professionals must be open and honest with patients when something goes wrong. In the first instance, there would be an apology to the patient and family/carer and if the harm had been moderate or serious, a letter would be written to the patient letting them know about the investigation.

Summary of complaints

The Countess of Chester Hospital

From 26 July 2017 to 25 July 2018 there were 38 complaints about urgent and emergency care.

The trust took an average of 42.8 days to investigate and close complaints. This did not meet the trust target of closing complaints within 40 days.

The table below shows the complaints broken down by subject:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>21</td>
<td>55.3%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>6</td>
<td>15.8%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>4</td>
<td>10.5%</td>
</tr>
<tr>
<td>Communications</td>
<td>3</td>
<td>7.9%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
<td>5.3%</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Number of compliments made to the trust

The Countess of Chester Hospital

From 26 July 2017 to 25 July 2018 there were 22 compliments received about the urgent and emergency care core service at the hospital.

During our inspection, we saw a large display board full of cards and letters thanking staff for the care either of themselves, or of their loved ones.
Is the service well-led?

Leadership

Local leaders and managers had the capability, experience and skills to run a service providing high quality sustainable care.

The urgent and emergency care service sat within the urgent care division, along with the medical assessment unit and the other medical wards. Many of the staff had been in the trust for several years, but they also had a new operational manager who had been in post for only a couple of months at the time of inspection, but they seemed enthusiastic and keen to improve access and flow through the department.

Staff we met told us that service leaders had a good understanding of frontline challenges within the department and that they were approachable, supportive and would always listen to staff if they wanted to discuss anything. On speaking to staff in the department, we heard of very positive working relationships.

Staff also told us that the deputy divisional director would also visit the department daily, however other staff told us they had not been much engagement with members of the Senior Management Team, although they had seen them doing walkabouts around the trust.

Staff in leadership roles were supported to develop and could follow the Acorn Leadership Model for staff that show potential. It offered them the opportunity to potentially change practice within the workplace.

Vision and strategy

The trust 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 trust vision was to deliver NHS care locally that made their staff and community proud by being safe kind and effective. The trust had set out to achieve this vision through three key strategic programmes: The West Cheshire Way (working with local healthcare partners to redesign services so they are more joined up), Integrated Specialist Services (which sees the hospital developing services as either a specialist centre, or through clinical networks in partnership with neighbouring hospitals) and The Model Hospital (which was how the trust would review core services to ensure they deliver quality).

Staff we spoke to were unable to clearly describe the trust vision and strategy and its goals. Within the department, we saw limited amounts of posters and flyers displaying the trusts values and staff were not able to clearly inform us of the detail of these.

Culture

Not all the staff we spoke with reported a very approachable, open and honest culture where leaders were easily accessible and supportive, as during the inspection, we were told about some issues of bullying.

During inspection however, we saw enthusiasm and a real sense of team working from speaking to staff. All the staff we spoke with were open, honest and very helpful.
The staff we met had worked in the department for varying amounts of time, but many of the senior staff had worked in the department for several years.

Through discussion with senior leaders, we were told that all staff are advised to raise any concerns and we were also told of the guardian available for junior doctors to speak to. Junior doctors also had their own monthly forum and we were told that issues of concern could also be brought to that meeting for discussion and escalation if required.

Senior staff told us that the trust had tried to embed a “lack of ceiling culture”, encouraging all levels and grades of staff to feel they could approach any other member of staff within the trust.

Whilst speaking with staff, we asked about the trust’s ‘Freedom to Speak Up Guardian/Champion’ and if they knew who this was and how to contact them. Out of all the staff we spoke with, none were aware of who this was and what this role entailed. ‘Freedom to Speak Up’ is a national integrated whistleblowing policy to help standardise the way NHS organisations should support staff who raise concerns and often the guardians for a trust will work closely with leadership teams, in supporting staff to raise concerns.

**Governance**

The trust used a systematic approach to aim to improve the quality of its services. There was a clear governance structure and clear lines of accountability for staff at all levels.

Within the urgent and emergency care service, staff were clear about their roles, what they were accountable for, and to whom they were accountable to. The services held monthly planned clinical governance meetings, also looking at complaints and compliments and they also held smaller, weekly meetings. During the meetings, members discuss risks and safety.

We were also told about governance meetings for urgent and emergency care which one of the matrons attended and we were also told about a further emergency department development meeting which took place on a Thursday each week, in which any needs, or reviews were discussed. During inspection, we were unable to review any records which confirmed the detail of these meetings.

Mortality and morbidity meetings, these were held once a month and members would review if there was any learning to be taken from the deaths. We were also told that patient deaths were reviewed by a dedicated consultant within the department.

**Management of risk, issues and performance**

The service did not always have effective systems for identifying risks, planning to eliminate or reduce them. Key risks were logged on the risk register; however, action had not been effective to mitigate the risks. We identified a number of risks on the inspection which had not been mitigated or acted upon.

There was a risk register for the service, as well as a divisional risk register, with action plans. We saw the risk register for the department and closely reviewed the risk register for the month of inspection. At the time of inspection there were nine items on the register and each was documented as being moderate or high risk, with the date the issue was raised and whether the risk was at a local or divisional level. We saw that most things we found to be risks during inspection were listed on the register. The risk register was then reviewed at Governance Board.

The trust had a system for reporting incidents and these were reviewed by a senior leader for the department to pull any common themes or trends, which they would then feedback on.
Performance in relation to targets and flow were monitored during each shift, as there was a patient board visible for staff to monitor and review and they could see how long patients had been in the department for.

**Information management**

The trust collected, analysed, managed and used information to support activities, using secure electronic systems with security safeguards.

There was an understanding of performance, which sufficiently covered and integrated people’s views with information on quality and operations.

Senior staff showed us the patient documentation on the computer system. This contained details of patient assessment, tests, diagnosis and plan of care. We were told that once a patient had left the department to go to another ward, the other ward was able to access the same patient record. Different disciplines could input onto the system and other staff could see what input the patient had received from other professionals.

There were computer stations with intranet and internet access available throughout the service and there were sufficient numbers of computers for staff to access information.

There were notice boards on one of the corridors containing positive patient feedback in the form of cards and letters, as well as safety thermometer information however, the information we saw was on a corridor that required swipe access to, so the public would be unable to view this.

The trust’s policies and procedures were accessible for all staff members via the intranet.

During inspection, one of our team members saw an open confidential waste box.

The trust had a Tele-tracking system in place, which oversaw bed management, as each patient had an identification band that was unique to them and there was a small communication centre within the hospital that had oversight of the systems in place, giving them oversight of where beds were available. The system would indicate if a bed needed cleaning or was ready for a new patient. This allowed staff to see at a glance if beds they were waiting for were available, however some staff saw this as a negative thing, as it meant reduced liaison with other colleagues. We were told that the porters received tasks through the system and the emergency department was a priority for these tasks. Staff also wore a device linked to the system, which meant that if needed information on how many staff had attended to a patient could be obtained.

**Engagement**

The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

In relation to staff engagement, there had been the development of a service which offered staff who had been through a difficult or upsetting situation with a patient/family the opportunity to speak to other people for support, but then this would be reviewed a month later to see if additional support was required for that individual. This had been set up following some research that one staff member had done into this area.

The service was also proud of development sit had made in respect of the introduction of the Emergency Multidisciplinary Unit and the benefit to patients that was having.
Senior staff told us that the introduction of new ideas, or ways of working had never been a struggle within the department, as all the staff were always willing to try new ideas, to make improvements, and were always supportive of each other as team members.

The Friends and Family tests were embedded in the trust and the service had scored 87% for this.

Feedback cards were available for patients/carers/relatives to complete to offer feedback regarding the service and care they had received.

Staff told us about a stakeholder event which had taken place in September 2017, when patients, teams and outside agencies, along with Public Health England did some work to develop a quality improvement programme for sepsis.

**Learning, continuous improvement and innovation**

Following the last CQC inspection, the service had made tried to make improvements to access and flow within the department. Some issues highlighted in the last inspection had not been addressed in a timely manner.

Since the last inspection, there had been a dashboard developed and there had also been the introduction of the safety huddle, which was proving to be effective.

Senior staff told us that as a department they were proud of the team, for always working together and putting on a smile, even when the department was so busy. During inspection, we saw clear evidence of this team working.

The department had introduced a bereavement re-call service, which was for any relative or carer to be invited to the department to speak with senior staff, if their loved one had died within the department.

Staff in the department were proud of the development of the emergency multi-disciplinary unit (EMU) which had been created, as this was aiding access and flow through the department, as well as ensuring some of the frailer patients were fast-tracked for services and interventions to aid their recovery.

On speaking to the safeguarding nurses and one of the Director of Nursing and Quality (who oversaw safeguarding), they were very enthusiastic to tell us about their development of a new specialist team. After lots of discussion, funding has been granted for new staff members to become part of a complex care team for adults in the trust, enabling more support and resources for vulnerable patients with complex needs within the trust.

The service was looking forward to the imminent building work that was due to commence, as this would offer more space and a better waiting area for children.

**Medical care (including older people’s care)**
Facts and data about this service

The medical division provides elective care in a range of clinical specialities which include: acute medicine, cardiology including coronary care, respiratory including the Respiratory Support Unit, diabetes and endocrinology, geriatric medicine including stroke services, gastroenterology including endoscopy, clinical haematology, acute oncology, rheumatology, dermatology, chemical pathology and palliative medicine.

The division has a total of 353 beds, 290 acute beds across ten wards at Countess of Chester Hospital and 63 intermediate care beds based at Ellesmere Port Hospital.

There is a cardiac catheter suite, cardio respiratory and vascular department and haematology and an oncology unit.

There is a therapies service within the division which provides services across the whole organisation and a rapid response service providing early supported discharge, working closely with the integrated discharge team. The division is also responsible for the co-ordination centre which undertakes all aspects of bed management and allocation for both urgent and planned care, via the tele tracking system. The team is also responsible for site management (out of hours).

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 24,451 medical admissions from June 2017 to May 2018. Emergency admissions accounted for 12,454 (50.9%), 283 (1.2 %) were elective, and the remaining 11,714 (47.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine - 11,163 admissions.
- Gastroenterology - 4,984 admissions.
- Clinical haematology - 3,793 admissions.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff received mandatory training in areas such as mental capacity, health and safety, fire, manual handling, infection control and medicine management. Staff we spoke to said they were up to date and had completed all there mandatory training.

Mandatory training completion rates

The Countess of Chester Hospital

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

A breakdown of compliance for mandatory training courses from July 2017 to June 2018 for
qualified nursing staff in medicine at The Countess of Chester Hospital below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>308</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>300</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>300</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>300</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>300</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>300</td>
</tr>
<tr>
<td>Health and safety (Slips, Trips and Falls)</td>
<td>300</td>
</tr>
<tr>
<td>Information governance</td>
<td>275</td>
</tr>
</tbody>
</table>

In medicine the target was met for one of the eight mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from July 2017 to June 2018 for medical staff in medicine at The Countess of Chester Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>92</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>88</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>88</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>88</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>88</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>88</td>
</tr>
<tr>
<td>Health and safety (Slips, trips and falls)</td>
<td>88</td>
</tr>
<tr>
<td>Information governance</td>
<td>67</td>
</tr>
</tbody>
</table>

In medicine the target was met for one of the eight mandatory training modules for which medical staff were eligible.

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

Safeguarding

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

Staff we spoke to knew how to make a safeguarding referral and where to find relevant forms and information on the intranet. Staff knew who the safeguarding lead was and how to contact them.

Staff recognised and proactively reported safeguarding adult concerns within the hospital. The reporting of safeguarding incidents on the trusts electronic system had been audited from August 2017 to July 2018 and the data suggests a significant increase in most categories. The medical care adult safeguarding referral made up 41% of the trusts total referrals across the year. This indicated a positive growth in awareness of safeguarding issues.
However, systems were not always followed to risk assess patients who may be suicidal, or have thoughts of self-harm. We spoke to one patient who spoke of suicidal thoughts and we found that no environmental or ligature risk assessments had been conducted. We brought this to the attention of the ward manager and a psychiatric referral was made and a psychiatrist attended to speak to the patient.

We reviewed the safeguarding adults annual report for April 2016 to March 2017. The purpose of the paper was to update the board of directors in relation to safeguarding adults within the trust and to provide details of the plans for safeguarding adults for 2017/18 in line with the adult safeguarding Strategy. It aimed to give assurance that the safeguarding policy was adhered to throughout the trust and that any issues within practice were identified and addressed.

The trust had a case of sexual exploitation lead within the safeguarding children team which reflected the requirements of the Local safeguarding children board (LSCB) multi agency cases of sexual exploitation (CSE) pathway. The cases of sexual exploitation lead attended the monthly multi-agency operational group, which met to discuss new cases and to review existing cases.

### Safeguarding training completion rates

#### The Countess of Chester Hospital

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

A breakdown of compliance for safeguarding training courses from July 2017 to June 2018 for qualified nursing staff in medicine at The Countess of Chester Hospital below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>276</td>
<td>317</td>
<td>87.1%</td>
<td>95.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>256</td>
<td>312</td>
<td>82.1%</td>
<td>95.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Preventing radicalisation level 1 and 2</td>
<td>253</td>
<td>317</td>
<td>79.8%</td>
<td>95.0%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In medicine the target was met for none of the three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from July 2017 to June 2018 for medical staff in medicine at The Countess of Chester Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>85</td>
<td>96</td>
<td>88.5%</td>
<td>95.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>78</td>
<td>89</td>
<td>87.6%</td>
<td>95.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Preventing radicalisation level 1 and 2</td>
<td>51</td>
<td>96</td>
<td>53.1%</td>
<td>95.0%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In medicine the target was not met for any of the three safeguarding training modules for which medical staff were eligible.

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

### Cleanliness, infection control and hygiene
The service did not always control infection risk well, or always keep themselves, equipment and the premises clean.

They used control measures to prevent the spread of infection which were not robust. We observed that staff were not always following their own policy to prevent the spread of infection, for example isolating patients effectively and displaying appropriate information on side rooms.

The trusts target for hand hygiene audits compliance was for all areas to routinely demonstrate 95% hand hygiene compliance. We saw hand hygiene audits were carried out for the medical wards between April 2018 and August 2018, a number of the areas scored between 50% and 80% compliance. For example, in August 2018 acute medical wards only scored 50% compliance.

The trust stated that full compliance was required with hand hygiene practices as it was a key element to ensuring that avoidable infections do not occur & therefore reducing the incidence of Health care associated infections (HCAI).

However, we observed staff washing their hands and using antiseptic gels before and after every episode of direct care or contact with a patient.

We also noted ‘Clean hands save lives’ posters displayed on ward 48, respiratory in-patients ward.

The medical areas carried out cleaning audits, we looked at results for audits conducted over two months; 1 August to 31 August 2018 showed 119 audits were completed, 93 were overdue and of the audits undertaken 44 failed to meet the trust standard. From 1 September to 30 September 2018 147 audits were completed, 108 were overdue and 61 showed a failure. Failure was due to a variety of failures including; bins not being emptied, areas not properly cleaned and chewing gum found.

We viewed the Equipment library and decontamination unit (ELDU) policy which was available on the hospital intranet.

We found the dirty utility room door on the coronary care ward propped open, as was the door on ward 51. The dirty utility on ward 51 had a jug containing disinfection, which was not labelled with contents or date. Keys were also left in cupboards containing; insect killer, sanitizer, and disinfection tablets.

Outside bay H on ward 50, we found dirty laundry sacks at the entrance to the bay and mop and bucket and dustpan and brush left unattended.

In wards 50 and 51 the doors leading to the toilets and shower rooms were dirty, with a considerable amount of dust collected on the door vents. We saw dirty blood pressure machines and hoists stored in the corridors with no evidence of them being cleaning.

We also observed all colour coded mops being stored together, we were told this was due to lack of space.

Patients with *Clostridium difficile (C.diff)* who were waiting to be discharged would not be accepted in the discharge lounge. However, patients with *Vancomycin-resistant enterococci (VRE)* and *Meticillin-resistant Staphylococcus aureus (MRSA)* were accepted if the infection control team had assessed the situation. Patients with infection control issues would sit in the main waiting area within the discharge lounge and staff would ensure that the chairs were cleaned with alcohol wipes post discharge.

The trust managed and decontaminating reusable medical devices in line with national guidance and all decontamination was carried out at the hospital. We visited the decontamination area which was attached to the endoscopy unit and staffed separately from the medical division. The decontamination unit also held a special license to decontaminate other trusts equipment.
The hospital was equipped with a tele-tracking system which worked well for alerting the bed turn around teams to when a patient had been discharged. The bed turnaround teams carried handheld devices and as soon as a patient was discharged they received an automatic alert so they could clean the bed space and decontaminate the mattress ready for the next patient.

**Environment and equipment**

The service did not have suitable premises in all wards and equipment was not always looked after well.

Additional beds for escalation were in use on the wards (40, 42, 44, 45, 48, 49, 50, 51 and 52) but the positioning of the beds impacted on access to fire doors, evacuation and a linen store cupboard, reduced the space around beds potentially impacting on patient privacy and dignity and the risk of cross infection.

On ward 51 an escalation bed was observed to be blocking the fire exit however, we were informed that if there was an evacuation this bed would go first through the doors.

Access to a linen store cupboard which was used daily by the nursing assistants was impeded and the patient’s privacy and dignity was limited due to staff constantly entering the patients bed space to gain entry to the cupboard.

The reduced space meant that the patients' chair was touching the adjacent bed which posed a possible infection risk.

The escalated bed spaces did not have access to oxygen, suction or an electrical plug socket which is recommended in the NHS Improvement Good Practice Guide: Focus on improving patient flow, July 2017.

In bay H, ward 50, there was a laminated A4 sign on the double doors which led to ward 51 to alert staff and patients that there could be an escalation bed on the other side of the fire doors, occupied by a patient. Due to the position of the sign it could be easily missed by staff, visitors and patients. The doors were unlocked and there was an occupied bed on the other side of the doors.

We found other fire exits on ward 50 and 51 inaccessible as equipment was being stored in front of the doors. On ward 51 bay C we found a large standard fan, a fluid stand stored in front of the fire doors. We found the same issue on Bay H.

Behind one fire exit which led to the oncology unit (ward 60) we found steps and blood pressure machines stored on the other side of the doors and it was very difficult to push open the doors due to the obstruction.

After the inspection the trust provided information regarding the risk assessments for the use of the additional beds during the winter period. The local fire service had been involved in the process.

Emergency call bells were not working efficiently on AMU. In a 6-bedded bay the lights would not activate when a call bell was pressed, therefore nurses could not identify which patient had called for assistance. The emergency bell rang in a different tone to the usually emergency bell; therefore nurses did not react in the appropriate way, nor could it be heard in certain areas of the ward. We were told by managers that the call bells had been ineffective for two years and had only been placed on the risk register two weeks prior to our visit. The risk had been placed on the local risk register, raised to divisional and lowered again with no explanation and was not questioned by the ward, manager.
Across the medical wards we visited we found the environment to be cluttered and there was a clear lack of storage on wards 50 and 51. Outside bay H, we found the corridor cluttered with; a portable linen cupboard, portable domestics station, dust pan and brush, industrial floor polisher, mop and bucket, dirty laundry sacks, wheel chairs, and a desk fan. This made the environment difficult for both staff and patients to manoeuvre.

The discharge lounge was well signposted and the facilities fulfilled patient’s needs. There was adequate seating, television and a drinks station for patients to help themselves.

We visited the endoscopy unit, which was a spacious, fresh, clean environment. As per the Joint advisory group (JAG) accreditation standards there was male and female separate changing area and waiting rooms with separate entrance/exits. There were three large changing rooms, well fitted out with, mirror, bench and hooks for clothes. The waiting areas for male and female were bright, airy and well decorated, equipped with televisions for patient use. Each area had an eight-bedded recovery area and a further second stage recovery area, which we also found to be light, airy, clean and well equipped with comfortable chairs.

On ward 47, the acute medical unit (AMU) we found that the environment was not always suitable for patients. We saw a profiling mattress leaning against the wall in the corridor and a trolley left over from meal time with dirty cutlery and left-over food on. The fire door to bay E was jammed open.

A store room in AMU was used to store intravenous fluids; we found 16 boxes of intravenous fluids stored on the floor and 12 bottles of sterile water. The store room was filled with a floor to ceiling drawer unit filled with intravenous fluids and staff had to climb a step ladder to access the intravenous fluids. The drawers were heavy and difficult to open due to the weight of the one litre bags stored within. Due to the limited space within the room, anyone opening the door could knock the steps.

AMU reported the clinic room on the divisional risk register. The risk was that the environment was not fit for purpose as it was not a suitable area for mixing intravenous medications. We visited the room and saw that the room was small and there was limited surface space for preparation.

We spoke to a female patient being barrier nurse in a side room in AMU as she had a potential infection. The patient had no toilet in the side room and had to use a commode. The toilet outside the bay was allocated to the male patients. The patient told us she would feel happier using a toilet rather than a commode.

AMU was well equipped with the right equipment for the needs of their patients and we saw 14 cardiac monitors on the unit.

The relatives’ room on AMU was not fit for purpose; it was dark, unclean and stored two bariatric chairs and stacks of plastic chairs.

Ward 48, respiratory in-patients also had problems with lack of storage facilities and we found that one male toilet/bathroom had had a change of use and was now a storage area for ward equipment.

We found two separate issues with patient toilets on ward 33 (stroke ward). The doors to the patient toilets opened inwards, allowing approximately a two inch between the door and the toilet. Therefore, it was difficult for nursing staff to open the door and assist a patient with personal needs. On the stroke ward the patient toilets had narrow doors; therefore it was very difficult for patients to enter the room with a walking aid, or get wheelchairs through. Managers told us they thought the ward was not fit for purpose as it was a very old ward.
The stoke ward also had a lack of storage facilities and an abundance of equipment stacked in the corridors to the wards, making it difficult for nursing staff and patients to manoeuvre.

We looked at the emergency equipment on the ward 33 (stroke ward) and found it to be all in order. There was evidence of consistent daily and weekly checks. The defibrillator was checked daily, with printouts evidencing this. The oxygen cylinder was also stored correctly and found to be full.

Every patient admitted to the hospital was asked to wear an electronic wristband so their movement can be tracked. Above each bed and doorway was an infra-red sensor which read the electronic chips in the patient wrist band as well as staff security cards and tags on equipment. This meant that the co-ordination centre knew the location and status of patients, staff and equipment at any moment in time.

Porters had hand-held devices which were linked to the tele-tracking system and enabled them to receive jobs instantly for transporting patient sand collecting equipment.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. They did not always record risk accurately and did not always know when to escalate, or ask for support when necessary.

The eight patient records we reviewed, we noted that there was evidence of risk assessments being completed appropriately. Risk assessments for venous thromboembolism (VTE), pressure ulcers, nutritional needs, and infection control risks.

However, falls assessments were not carried out thoroughly, simple questions were asked on admission to ascertain whether the patient was at risk of falls, but this was not followed through.

There was no objective criteria for a falls risk assessment and no standard training, therefore there was inter-user variability in formulating a falls risk score. Only after a patient fell was a vision assessment, lying and standing blood pressure assessment and the assessment for the presence of absence of delirium, carried out.

National audit of inpatient falls 2017 showed that the trust did not meet the national aspirational standards; vision assessment 17%, lying and standing blood pressure assessment 10% and the assessment for the presence of absence of delirium carried out 21%. The most prevalent type of serious incident was slip, trips and falls (31 incidents, 39.2% across the trust), suggesting issues with assessments. Fifteen of the serious incidents (53.6%) related to slips, trips or falls. Thirteen of these were unwitnessed, suggesting issues with monitoring vulnerable patients who are at risk of falls. All patients who suffered falls were elderly patients.

There was no visual indication at the patient’s bedside to inform staff that the patient was at risk of fall.

On the wards we found varying levels of competency with regards to knowledge and assessment of sepsis. Staff in the medical wards had not had appropriate training in sepsis awareness, therefore they were unable to access the patient for sepsis and escalate care. We were told by one manager that leaflets had been given out to staff from a stand in the canteen to make them aware, but there had been no formal training and they ‘assumed’ that nursing staff knew about the sepsis pathway. We spoke to the medicine leads who told us that the sepsis pathway had been recently updated to the new NEWS 2 tool, to meet national guidelines. NEWS 2 is an updated scoring system which includes a focus prioritising the detection of serious sepsis in patients and
those at high risk of infection. Medical leads told us that training had not yet been implemented; staff had purely been made aware of sepsis. A sepsis six trust roll out was not scheduled until 27 November 2018, the position on sepsis was described as a transition and the medical wards intended to train link nurses for sepsis.

In relation to the management of serious infection, the trust told us that sepsis was recognised as an area for improvement. A sepsis group met bi-monthly to monitor sepsis CQUIN data. The sepsis pathway has now been standardised and the trust had a separate paediatric and adult sepsis pathway.

During our visit we raised concerns over the escalation of National early warning scores (NEWS).

We reviewed eight patient records across the medical wards and found that a NEWS score of between five and eight had been recorded for six of the patients, however no escalation had been carried out and no sepsis screening tool commenced.

An audit was carried out by the outreach time for wards 46, 47 50 and 51. The audit checked ten random patient records from each ward and found that all records had the correct identifiable information available and the date and time was recorded for each entry. On all the wards, the charts showed a high number (between 70% and 100%) showing that a full set of observations had been recorded at each intervention. However, all wards scored low for re-checking observations in line with NEWS 2 escalation requirements. The lowest being ward 50 with only 50% of patient’s observations re-checked.

Staff were not confident in when to escalate a patient from the NEWS score. The trust modified early warning score and fluid balance audit for January 2018 to May 2018 showed wards, 33, 48 and 50 had failed to calculate scores for six and 24-hour totals. Staff we spoke to knew that if they did have cause to escalate a patient that they would speak to a junior doctor and after 5pm they would escalate to the Doctor, or bleep the medical team for immediate response.

The cardiac catheter suite told us that they used the National early warning score (NEWS) to monitor patients and knew when to escalate a patient and who to contact. The outreach team would attend the unit if staff had any concerns regarding a patient. There had been incidents where patients had scored high on NEWS however the patient had to remain on the catheter suite with staff caring for them there and the unit did not always have the right skill mix to care for such acuity patients.

The medical ward had recently implemented a new ‘Safe care’ acuity tool, which involved a safety huddle each morning with the ward manager, where staff numbers, competencies and patient acuity are discussed for the day.

Ward 33, the acute stroke and rehabilitation unit was made up of 20 rehabilitation beds, four hyper acute beds, plus a trolley and a hyperactive bay which was kept free to respond to acute admissions.

The acute medical unit (AMU) had two bays (B and C) allocated for cardiac patients. Nurses from AMU were assigned to look after these patients. The ratio was one registered nurse to seven cardiac monitored patients, in comparison to the cardiology (monitored) unit where the ratio was four, trained cardiac nurses, to ten cardiac monitored patients.

**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 to provide the right care and treatment.
We were told that staff were regularly and frequently moved to other wards and areas of the hospital where they were short staffed. Staff from the medical wards were moved between all areas of the hospital except surgical wards. We were told that nurses who were moved to the respiratory wards were not always able to access the IT system and could not issue medication, order bloods, or add to the patient’s documents. Agency staff could not look after tracheostomy patients, or non-invasive ventilation patients.

The endoscopy unit had recently employed two gastrointestinal nurse (GIN) facilitators in the unit.

**Planned vs actual**

**The Countess of Chester Hospital**

The trust has reported their staffing numbers for nursing staff within medicine at The Countess of Chester Hospital below for the period April to June 2018.

<table>
<thead>
<tr>
<th>Department / unit name</th>
<th>Actual staff (WTE)</th>
<th>Planned staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cath lab</td>
<td>6.8</td>
<td>6.0</td>
<td>113.1%</td>
</tr>
<tr>
<td>Nursing department</td>
<td>11.7</td>
<td>11.0</td>
<td>105.9%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8.4</td>
<td>8.0</td>
<td>105.0%</td>
</tr>
<tr>
<td>Renal care unit</td>
<td>14.6</td>
<td>14.0</td>
<td>104.6%</td>
</tr>
<tr>
<td>Nursing services</td>
<td>18.6</td>
<td>18.0</td>
<td>103.4%</td>
</tr>
<tr>
<td>Nurse management</td>
<td>9.2</td>
<td>9.0</td>
<td>102.2%</td>
</tr>
<tr>
<td>Oncology</td>
<td>1.5</td>
<td>1.5</td>
<td>102.2%</td>
</tr>
<tr>
<td>Matron Aw</td>
<td>76.3</td>
<td>75.0</td>
<td>101.7%</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>14.2</td>
<td>14.0</td>
<td>101.4%</td>
</tr>
<tr>
<td>Acute medical unit</td>
<td>32.1</td>
<td>32.0</td>
<td>100.3%</td>
</tr>
<tr>
<td>Breast</td>
<td>3.4</td>
<td>3.4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0.8</td>
<td>0.8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Elderly care</td>
<td>3.0</td>
<td>3.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>4.0</td>
<td>4.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical assessment unit medical</td>
<td>1.0</td>
<td>1.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Planned divisional support services</td>
<td>2.0</td>
<td>2.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Primary care</td>
<td>2.0</td>
<td>2.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>4.0</td>
<td>4.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Therapies inpatients</td>
<td>1.0</td>
<td>1.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Matron Cw</td>
<td>62.1</td>
<td>63.0</td>
<td>98.6%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>1.0</td>
<td>1.0</td>
<td>96.0%</td>
</tr>
<tr>
<td>Specialist nursing</td>
<td>21.0</td>
<td>22.0</td>
<td>95.2%</td>
</tr>
<tr>
<td>Short stay unit</td>
<td>4.6</td>
<td>5.0</td>
<td>92.5%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>0.6</td>
<td>1.0</td>
<td>60.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>303.8</strong></td>
<td><strong>301.7</strong></td>
<td><strong>100.7%</strong></td>
</tr>
</tbody>
</table>

Ten of the 24 departments/units were listed as being over-established.

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

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a vacancy rate of 3.0% for nursing staff in medicine at The Countess of Chester Hospital. The trust reported no vacancy target.

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

Turnover rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a turnover rate of 11.8% for nursing staff in medicine at The Countess of Chester Hospital; this was higher than the trust target of 10%.

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

Sickness rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a sickness rate of 3.3% for nursing staff in medicine at The Countess of Chester Hospital; this was lower than the trust target of 3.65%.

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

Bank and agency staff usage

The medical wards used both bank and agency staff. The bank staff used were a combination of nurses from the medical wards and elsewhere at the hospital.

During our inspection we were told that nursing and support worker staffing was a challenge on some wards. Although staffing fill rates percentages show established staffing numbers were satisfactory, other data shows actual care hours per patient were always significantly less than that the required levels during October 2018. There was high use of bank and agency staff on some wards in particular on AMU. It also showed that even with the high percentage of bank and agency staff, there were still significant numbers of shifts that remained unfilled.

<table>
<thead>
<tr>
<th>October 2018</th>
<th>Ward</th>
<th>Actual care hours per patient</th>
<th>Required care hours per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AMU</td>
<td>6.40</td>
<td>8.56</td>
</tr>
<tr>
<td></td>
<td>33</td>
<td>6.78</td>
<td>7.55</td>
</tr>
<tr>
<td></td>
<td>34</td>
<td>4.25</td>
<td>5.41</td>
</tr>
<tr>
<td></td>
<td>42</td>
<td>9.38</td>
<td>7.08</td>
</tr>
<tr>
<td></td>
<td>43</td>
<td>7.60</td>
<td>8.32</td>
</tr>
<tr>
<td></td>
<td>48</td>
<td>6.30</td>
<td>6.83</td>
</tr>
<tr>
<td></td>
<td>49</td>
<td>5.33</td>
<td>6.99</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>6.01</td>
<td>7.96</td>
</tr>
<tr>
<td></td>
<td>51</td>
<td>5.94</td>
<td>8.6</td>
</tr>
<tr>
<td></td>
<td>54</td>
<td>5.63</td>
<td>7.46</td>
</tr>
</tbody>
</table>
The Countess of Chester Hospital

The table below shows the numbers and percentages of hours in medicine at The Countess of Chester Hospital from July 2017 to June 2018 that were covered by qualified nursing bank and agency staff or left unfilled by department.

Of the 114,342 total working hours available, 9.4% were filled by bank staff and 3.8% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, 6.8% of the available hours were unable to be filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward / unit name</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>Not filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Acute medical unit (Ward 47)</td>
<td>14,660</td>
<td>1,478</td>
<td>10.1%</td>
<td>1,149</td>
</tr>
<tr>
<td>Ward 42 Cathedral Ward</td>
<td>13,446</td>
<td>1,785</td>
<td>13.3%</td>
<td>214</td>
</tr>
<tr>
<td>Ward 48 Northgate Ward</td>
<td>8,442</td>
<td>44</td>
<td>0.5%</td>
<td>151</td>
</tr>
<tr>
<td>Ward 33 Trinity Ward</td>
<td>8,429</td>
<td>408</td>
<td>4.8%</td>
<td>0</td>
</tr>
<tr>
<td>Endoscopy suite</td>
<td>8,399</td>
<td>348</td>
<td>4.1%</td>
<td>0</td>
</tr>
<tr>
<td>Ward 50</td>
<td>7,038</td>
<td>1,323</td>
<td>18.8%</td>
<td>194</td>
</tr>
<tr>
<td>Ward 51</td>
<td>6,836</td>
<td>573</td>
<td>8.4%</td>
<td>126</td>
</tr>
<tr>
<td>Cath lab</td>
<td>6,563</td>
<td>477</td>
<td>7.3%</td>
<td>0</td>
</tr>
<tr>
<td>Ward 49 Foregate Ward</td>
<td>6,516</td>
<td>1,188</td>
<td>18.2%</td>
<td>534</td>
</tr>
<tr>
<td>Ward 43 Meadows Ward</td>
<td>6,476</td>
<td>896</td>
<td>13.8%</td>
<td>19</td>
</tr>
<tr>
<td>Renal unit</td>
<td>6,405</td>
<td>40</td>
<td>0.6%</td>
<td>0</td>
</tr>
<tr>
<td>Ward 34 Priory Ward</td>
<td>6,246</td>
<td>896</td>
<td>14.3%</td>
<td>481</td>
</tr>
<tr>
<td>Short stay unit - now Acute Medical Unit (AMU)</td>
<td>3,580</td>
<td>1,052</td>
<td>29.4%</td>
<td>1,494</td>
</tr>
<tr>
<td>Ward 60 haematology oncology suite</td>
<td>2,669</td>
<td>15</td>
<td>0.6%</td>
<td>0</td>
</tr>
<tr>
<td>Dementia care team</td>
<td>2,631</td>
<td>40</td>
<td>1.5%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Medicine total</strong></td>
<td><strong>114,342</strong></td>
<td><strong>10,739</strong></td>
<td><strong>9.4%</strong></td>
<td><strong>4,362</strong></td>
</tr>
</tbody>
</table>

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

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

There was sufficient medical cover outside normal working hours and at weekends should patients need to see a doctor. Consultant cover was available on site from 9am to 6pm daily and on call outside of these hours. We were told that all consultants were within 30 minutes of the hospital.

The medical service had ten consultants, of which nine held a general internal medicine certification.
The medical unit also had three Specialty and associate specialist (SAS) doctors. The SAS doctors were recognised as consultants at the trust. These doctors had completed a recognised training scheme (five to six years), completed a membership exam and had obtained a certification of completion of training (CCT), recognised as a specialist. The SAS doctors were permanent members of staff and included in the on-call rota.

The medical department also employed locally employed doctors (LED’s), doctors outside of training, though these were not often employed for more than six months.

We spoke to a junior doctor, foundation year one, who formed part of the on-call rota for the medical department. Their shifts included; 9am to 9pm weekdays, 9am to 5pm weekends and twice per rotation 4am to midnight. When on call, the junior doctor would be available by bleep and would cover anywhere in the hospital.

**Planned vs actual**

**The Countess of Chester Hospital**

The trust has reported their staffing numbers for medical staff within medicine at The Countess of Chester Hospital below for the period April to June 2018.

<table>
<thead>
<tr>
<th>Department / unit name</th>
<th>Actual staff (WTE)</th>
<th>Planned staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>3.3</td>
<td>3.0</td>
<td>110.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>5.3</td>
<td>5.0</td>
<td>105.9%</td>
</tr>
<tr>
<td>Breast</td>
<td>3.0</td>
<td>3.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Elderly care</td>
<td>13.0</td>
<td>13.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Histopathology</td>
<td>6.5</td>
<td>6.5</td>
<td>100.0%</td>
</tr>
<tr>
<td>Microbiology</td>
<td>3.8</td>
<td>3.8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Planned divisional support services</td>
<td>1.0</td>
<td>1.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Primary care</td>
<td>0.8</td>
<td>0.8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>7.0</td>
<td>7.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Unplanned divisional support services</td>
<td>4.0</td>
<td>4.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>8.9</td>
<td>9.0</td>
<td>98.9%</td>
</tr>
<tr>
<td>Medical Assessment Unit</td>
<td>11.8</td>
<td>12.0</td>
<td>97.9%</td>
</tr>
<tr>
<td>Diabetes/endocrinology</td>
<td>4.9</td>
<td>5.0</td>
<td>97.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>6.9</td>
<td>8.0</td>
<td>85.9%</td>
</tr>
<tr>
<td>General medical</td>
<td>17.0</td>
<td>20.0</td>
<td>85.0%</td>
</tr>
<tr>
<td><strong>Medicine total</strong></td>
<td><strong>97.1</strong></td>
<td><strong>101.1</strong></td>
<td><strong>96.0%</strong></td>
</tr>
</tbody>
</table>

Two of the 15 departments/units were listed as being over-established.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

**The Countess of Chester Hospital**

From July 2017 to June 2018, the trust reported a vacancy rate of 17.0% for medical staff in...
medicine at The Countess of Chester Hospital. The trust reported no vacancy target.  
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a turnover rate of 20.2% for medical staff in medicine at The Countess of Chester Hospital; this was higher than the trust target of 10%. The trust has specifically stated that trainee grades are not included in this figure.  
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a sickness rate of 1.1% for medical staff in medicine at The Countess of Chester Hospital; this was lower than the trust target of 3.65%.  
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The Countess of Chester Hospital

We have been unable to calculate bank and agency usage as a proportion of the total number of shifts available because the total shifts available provided by the trust does not include permanent staff.

The table below shows the numbers of hours in medicine at The Countess of Chester Hospital from July 2017 to June 2018 that were covered by medical bank and locum staff or left unfilled.

In total, 8,838 hours were filled by bank staff and 7,114 hours were covered by agency staff to cover sickness, absence or vacancy for medical staff.

In the same period, 1,469 hours were unable to be filled by either bank or locum staff.

<table>
<thead>
<tr>
<th>Ward / unit name</th>
<th>Number of bank hours</th>
<th>Number of locum hours</th>
<th>Number of unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of the elderly</td>
<td>3,514</td>
<td>524</td>
<td>600</td>
</tr>
<tr>
<td>Acute medicine</td>
<td>1,908</td>
<td>533</td>
<td>227</td>
</tr>
<tr>
<td>Diabetes/endocrine</td>
<td>393</td>
<td>2,004</td>
<td>149</td>
</tr>
<tr>
<td>Haematology</td>
<td>688</td>
<td>1,840</td>
<td>0</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>482</td>
<td>408</td>
<td>461</td>
</tr>
<tr>
<td>Cardiology</td>
<td>85</td>
<td>1,101</td>
<td>13</td>
</tr>
<tr>
<td>General medicine</td>
<td>1,032</td>
<td>81</td>
<td>0</td>
</tr>
<tr>
<td>Respiratory</td>
<td>733</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Microbiology</td>
<td>0</td>
<td>623</td>
<td>0</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medicine total</td>
<td>8,838</td>
<td>7,114</td>
<td>1,469</td>
</tr>
</tbody>
</table>

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

In June 2018, the proportions of consultant and junior (foundation year 1-2) staff reported to be working at the trust were higher than the England averages.

Staffing skill mix for the 98-whole time equivalent staff working in medicine at Countess of Chester 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>51%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>13%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>29%</td>
<td>22%</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 - Medical (01/06/2018 - 30/06/2018))

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

We looked at eight patient records across the medical services and found them legible and the name and grade of doctor/nurse reviewing the record was clearly documented. On all eight records we saw that the nursing assessment had been carried out and on all but one record, a care plan was included all identified care needs.

One patient notes omitted to identify the patients’ falls’ history, even though they had been admitted with a fall.

Only one patient we reviewed had a ‘Do not attempt cardiopulmonary resuscitation’ (DNACPR) form, however this was accurately completed and an associated Mental Capacity Act (MCA) assessment, which was within a patient’s paper records.

Staff in the discharge lounge had access to patient’s electronic notes.

The unit was using electronic prescribing; this has been shown to have an impact on patient safety by reducing medication and transcription errors.

We looked at the records of a patient with a grade four pressure ulcer and saw that repositioning had been carried out and documented.

Records were not always manged well and on a number of medical wards we found the records stored insecurely in the corridors. Wards included; ward 48, respiratory in-patients ward.
However, in the coronary care unit (monitored) we saw that the records were stored in a lockable cabinet.

Once a patient’s tele-tracking bracelet was removed, the patient was no longer shown on the hospital system. However, the discharge lounge kept paper records of time in and out of the unit and the information was fed into the IT system. It was also used as a register in case of a fire.

During our visit to the endoscopy unit we saw two, large, clear plastic containers in top of a domestic waste bin in the corridor. One container was empty and the other contained tissue biopsy samples from the mornings endoscope clinics. We were told by the unit manager that the specimens were collected at the end of each day and taken to the laboratory. Each specimen had patient’s personal details on and could be seen through the box. After raising the issue, we revisited the unit to find the samples stored in a secure dirty utility room for the porters to collect. We also saw a new statement of purpose in relation to the storage samples for collection.

**Medicines**

Best practice was followed when prescribing, giving and recording medicines, however not always followed when storing medicines. Patients received the right medication at the right dose at the right time.

We looked at medicine storage on ward 50 where we found that medicines were appropriately stored with a digital lock on the door, known to staff. All medicines were locked in cupboards and fridges. We saw separation of internal and external liquids and controlled drugs were stored inside a separate metal cupboard. However, on ward 51 there was no door leading to the medicine store room.

Expiry dates on drugs were checked as part of the administration process by nursing staff. We saw this practice and that controlled drugs were also checked by nursing staff. However, we did find a quantity of drugs that had expired which included; Tramadol M/R 100mg-expired 08/2018, Ipratropium Steri-neb 250mcg inhalation in cupboard-expired 10/2017 and various dressings had expired.

We also found issues with liquid preparations; Morphine sulphate solution, 300ml had been dispensed on 12 September 2018, but there was no opening date recorded on the bottle, which directed that it should not be used after 90 days. Oxycodone 5mg5ml -250 ml stock bottle, also failed to display an opening date.

The fridge portable appliance testing (PAT) sticker stated the test needed to be redone on in March 2018.

All drugs stored in the secure fridge were found to be within their manufacturing recommended expiry dates.

Fridge temperature monitoring was not completed 59 times since 1 January 2018. Fridge temperature maximum recorded temperature since last record, should be 24 hours, however this was not the case. The maximum temperature was above eight degrees on 200 occasions since 1 January 2018. The highest maximum temperature recorded was 26.8 degrees on 1 January 2018 and no action was recorded as being taken. The only action recorded on the record sheets was “Cleaned”. The temperature was over 8 degrees by quite a large amount over this period, temperatures varied between 9-26.8 degrees, with days of readings being the same.

We raised this with staff who stated that there was confusion as to who was recording the temperature.
Staff nurses told us that they had no formal training in using the temperature monitor on the fridge and were unaware of the trust policy. They said that they would contact estates if there was an issue, but did not know to contact the pharmacy. The ward manager stated that they were unaware of the temperatures on the fridge being above eight degrees and did not complete a medicine storage check or audit.

Furthermore, we found that the room temperature was not monitored or recorded. The medicine room was very warm and discussion with staff indicated this was a year around issue. We were told that a thermometer had been left in room briefly over the summer, but staff were unaware of any outcome from this action.

There were no cleaning schedules available for the clinic room on ward 50.

We saw that the contact details for the pharmacy were laminated and visible to staff.

The Pharmacy provided a top-up of stock for the ward.

Unwanted medicines were disposed of by two routes; a blue medicines disposal bin, labelled and dated 11 November 2018 and a return to pharmacy green box-collected by pharmacy staff.

A controlled drugs register was available and was legible with staff daily balance checks recorded and one observed.

No disposal kits were available to review as all had been transported back to pharmacy for disposal.

In the endoscopy Clinic we looked at treatment room two and found the door to the room open, although the room was not in use. However, the two drugs cupboards were locked, with keys held by qualified staff.

We checked a sample of items on the two trolleys containing medical equipment and we found all were within the manufacturer’s recommended expiry dates.

Medical gases were within expiry date and secured on a trolley.

We found that fridge temperature monitoring was not recorded on a standard trust forms, and the minimum/maximum temperature of the fridge over the previous 24-hour period, was not being recording.

We saw that all items in the fridge were within their expiry dates.

We saw good record keeping for controlled drugs, quantities were correct and matched their entries and double signatures were seen on all records and three stock checks were carried out daily.

Pharmacy staff completed a balance check on 16 July 2018 and again on the 18 October 2018. Errors seen within the controlled drugs register had been recognised, reviewed and signed accordingly.

The cardiac unit was undergoing renovations with the fitting of a new metal controlled drugs cupboard, so we were unable to verify storage security of the medicines in the room. Intravenous fluids were stored in locked cupboards in the store room and segregated, with the key held by the ward manager. Control drugs registers for the two cupboards were in order and we checked the expiry dates for two items against the register entry.

We saw evidence that daily nurse stock checks were carried out, as well as three monthly pharmacy balance checks.
There were similar problems with fridge temperatures and only single temperatures were monitored and did not include minimum and maximum temperatures. Records seen from 1 August 2018 were all between ranges of two and eight degrees. Again, the room temperature was not monitored in any of the rooms containing medicines.

We found a blank pad of outpatient prescription forms on the bottom of a trolley in the main area of ward, although they could only be dispensed in the hospital outpatients’ pharmacy.

The emergency trolley was located in main ward area and was not sealed at the time of the inspection. The deputy staff nurse informed us that they were completing their weekly date checking and had removed some out of date dressings.

We looked at the emergency medicine box which was within the expiry date. However, daily checks were around seals and not contents themselves.

The defibrillator was in working order, with extra pads available.

In ward 48 we looked at six patient prescriptions which were prescribed electronically, except for IV and insulin medicines which were prescribed separately on paper forms. All six records we examined had patient’s allergies recorded on the record. No missed doses were seen on the records examined. One patient had swallowing difficulties and medicine was prescribed via a percutaneous endoscopic gastrostomy (PEG) tube. This was noted on the electronic record for each medicine.

We did see discrepancies in one patient’s prescription record; the patient was prescribed co-careldopa, (a drug to relieve symptoms of Parkinson’s disease) which should be given at regular intervals of 08:00, 12:00, 18:00, 22:00, according to the prescription record. However, the medicine was recorded as being administered each day at about 06:00 am. The exception to this was 07 November 2018 when the doses were administered at 9.54am, 12.55am, 5.57pm and 9.53pm.

We found that all patients were prescribed tinzaparin after *venous thromboembolism (VTE)* assessment, (tinzaparin is an anticoagulant that helps prevent the formation of blood clots).

Pharmacy had a clinical input which was clearly seen on three records, including the patient being administered through the PEG (via an enteral tube).

Antibiotic prescribing was in line with national guidelines, with one off stat doses and stop/start dates recorded on records.

We looked at an emergency trolley which was located in the discharge lounge and found it was correctly sealed. We checked a sample of items which we found to be in date. Checks were carried out daily; however, again we found the checks were around seals and not the contents themselves.

On ward 47 we found insulin stored in a fridge which should have been disposed of on 13 November 2018, although record checks had been completed on 13 and 14 November this had been over looked.

**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.

Learning from clinical incidents was shared with staff at the daily safety brief; any key messages were printed from the internal electronic reporting system and discussed. There was an open ethos to share from experiences and incidents and we were told about a drug error on ward 51 which was investigated by the ward manager and learning was shared on the electronic reporting system. Actions resulted in the nurse attending a medicine management study day and a reflection report.

Multidisciplinary mortality and morbidity reviews were held on a monthly basis, which was chaired by the medical director. All cases were reviewed through this process to identify key learning and to identify any actions if appropriate.

However, ward managers told us that they were not invited to the mortality and morbidity meetings, regardless whether the death had occurred in their ward. Managers told us that they would benefit from attending the meeting and information from the meetings was not disseminated down to them. We spoke to the medicine lead who told us that the meetings were clinical staff only and managers did not attend to prevent the numbers at the meeting being too large. We were told that relevant information was shared with managers, in one to one meetings.

**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 October 2017 to September 2018, the trust reported no incidents which were classified as never events for medicine.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 30 serious incident(s) (SI) within medical care which met the reporting criteria set by NHS England from October 2017 to September 2018. A breakdown of the incident types reported is in the table below.

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>14</td>
<td>46.7%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>6</td>
<td>20.0%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>5</td>
<td>16.7%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>3</td>
<td>10.0%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

*(Source: Strategic Executive Information System (STEIS))
Safety thermometer

The service did not use safety monitoring results well.

In ward 50 and 51 the frailty ward, we were told that all patients admitted were treated as ‘fall risk’, but informed that not all patients were being assessed. We were told that this was down to shortage of staff. This had been noted by the hospital and on 1 October a prompt for staff to carry out falls risk assessments was added to the patient record IT system.

We looked at eight sets of patient records across the medical wards and found two patients had been admitted to the ward as a result of a fall, however the falls risk assessment recorded that the patient was not at risk of falls. A third patient fell whilst on the ward and a falls risk assessment was carried out afterwards, but nothing was recorded or changed in their care plan.

After a patient had fallen, a falls form was completed; ‘Medical post fall proforma’ which was then added into the patients notes.

The ward managers told us that the falls lead had started teaching small groups on each ward the importance of carrying out falls risk assessments.

Throughout the medical wards we saw boards displaying performance on the unit. On ward 48, respiratory ward the information displayed informed staff, patients and families that; the last case of C.Diff had been six days ago, the last fall had been a day ago, there had been no pressure ulcers and it had been 100 days since the last recorded case of MRSA on the unit.

We saw evidence of appropriate pressure ulcer care, including the use of pressure ulcer mattresses, two hourly turns, and comfort rounds throughout the day. We saw an added prompt to staff on the back of the ward safety brief, reminding staff to carry out half hour visual checks on patients. Ward 48 had no pressure ulcers for the month of November. We reviewed a patient with a pressure ulcer had been referred to the tissue viability nurse.

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 13 new pressure ulcers, 10 falls with harm and six new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and catheter urinary tract infections at Countess of Chester Hospital NHS Foundation Trust

1
**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Patients received care and treatment in line with evidence based practice and national guidelines. Clinical audits included monitoring compliance with National institute for health and care excellence (NICE) and royal colleges' guidelines. However, changes to NICE guidelines were not cascaded to team level an only some ward managers attended divisional governance reviews which discussed NICE guidelines.

Across the medical division we saw participation in a number of local and national audits in order to review the effectiveness of care and treatment. The medical assessment unit participated in a local hand washing audit a national high impact interventions audit.

Guidelines and polices were available on the trust intranet. Staff were aware of how to access guidelines and policies on the trust intranet and in ward areas. Staff had access to previous audits and findings, which were also discussed and recorded as part of ward minutes.
Medical services participated in the Joint advisory group on gastrointestinal endoscopy (JAG) and the endoscopy unit was JAG accredited. JAG accreditation ensures the quality and safety of patientcare by defining and maintaining the standards by which endoscopy is practiced.

The endoscopy unit also ran a bowel screening programme and had an in-house Hospital sterilisation and disinfectant unit (HSDU) who had achieved ISO9001 and medical devices. ISO 9001 demonstrates the ability to consistently provide products and services that meet customer and regulatory requirements.

**Nutrition and hydration**

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

We looked at eight sets of patients notes and all eight recorded that a nutritional risk assessment and assessment of nutritional status had been carried out.

Wards 50 and 51 had protected meal times and this was displayed on signs around the wards. On ward 48, respiratory in-patient’s unit we saw leaflets available for patients on nutrition support for chronic obstructive pulmonary disease (COPD).

Snacks were made available if patients missed meal times due to being away from the ward. We spoke to one patient on ward 48 who had been brought in by ambulance at night and a snack was brought to them on the ward.

In the discharge lounge a water machine was available for patients and a tea/coffee station, where patients could help themselves for refreshments. If a patient had ordered food on a ward and had then been moved to the discharge lounge, the meal was transferred for them.

Ward 51 had two house keepers who helped patients who required assistance with eating. They also monitored patients who had declined their meal, or not eaten, by feeding back to the nurse and recording in the patients notes.

**Pain relief**

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

All patients we spoke to across the medical wards were happy that their pain relief was assessed accordingly and that they were offered the appropriate pain relief when necessary.

There was no pain team available to acute medical unit (AMU). The unit monitored patients pain using a pain score on the National early warning score (NEWS) chart. The trust's ‘guideline to pain assessment outlined the process for staff to assess patients’ pain symptoms, including the use of the ‘Abbey Pain Scale’ for patients living with dementia or who cannot verbalise. However, we did not see clear evidence to show that the Abbey Pain Scale tool was consistently by all staff in the wards we inspected.

**Patient outcomes**
Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

We looked at the National confidential enquiry into patient outcome and death (NCE POD) for July 2017 for Non-invasive acute ventilation (NIV), the purpose of the enquiry was to improve the quality of care provided to patients receiving acute non-invasive ventilation (NIV). Issues in relation to the timeliness, appropriateness, location, level of care and competency of staff treating patients with acute NIV were highlighted. Outcomes showed that there had been improvements in the escalation decision in an event of failure to respond to NIV. The length of hospital stay had also been reduced by two days in current smaller cohort of patients; however the mortality had remained the same over past five years.

The medicine division participated in numerous audits, which included in the discharge lounge. An example of an audit conducted was on the volume of transfers and times of patients admitted to the unit. They did not carry out any clinical audits in the unit.

An audit by the stroke society had been conducted on patients discharged from the stroke ward; the outcome was that patients wanted an extended rest period as they were tired by visitors. The ward actioned this and had recently reduced visiting times to the ward from 11am to 7pm to 1pm to 7pm.

**Risk of readmission**

In CQC insight for acute trusts, emergency readmissions for acute myocardial infarction were worse at the trust from January to December 2017 compared to nationally, at 160.8 compared to the average of 100. However, this was an improvement from 259.4 in the previous year.

We spoke to management in the respiratory in patient’s ward who told us that some of their patients felt safe in their care and wanted to be admitted. They were aware of the high figures for readmission and were following a number of pathways, which included; an asthma plan, pulmonary rehabilitation, smoking cessation and COPD completed prior to discharge.

The services did not regularly review the effectiveness of sepsis management through local and national audit. All Sepsis CQUIN targets were missed in quarter four. The trusts performance report for June 2018 reported that this was anticipated; with the improvements made to the data sampling and collection process they had seen a reduction overall in compliance to the number of eligible patients screened.

**The Countess of Chester Hospital**

From May 2017 to April 2018, patients at The Countess of Chester Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Patients in clinical haematology and gastroenterology had lower than expected risks of readmission for elective admissions compared to the England averages.

- Patients in respiratory medicine had a higher than expected risk of readmission for elective admissions compared to the England average.

**Elective Admissions - The Countess of Chester 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 site based on count of activity.

From May 2017 to April 2018, patients at The Countess of Chester Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in general medicine and geriatric medicine had lower than expected risks of readmission for non-elective admissions compared to the England averages.
- Patients in cardiology had a similar to expected risk of readmission for non-elective admissions compared to the England average.

### Non-Elective Admissions - The Countess of Chester 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 site based on count of activity.

#### Sentinel Stroke National Audit Programme (SSNAP)

Countess of Chester Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in the latest audit, August to November 2017. This is an improvement on the B grade achieved in the previous four audits.

#### Countess of Chester Hospital

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16-Mar 17</th>
<th>Apr 17-Jul 17</th>
<th>Aug 17-Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
</tr>
</tbody>
</table>

In terms of patient centred performance, Countess of Chester Hospital scored an A or B in all but two domains in each of the last four audits. In the most recent audit, August to November 2017, the two areas where the hospital scored below grade B were the stroke unit and speech and language therapy where the scores were C and E, respectively.
In terms of team centred performance, scores were generally the same as for patient centred care. However, the hospital scored a B for the stroke unit in the August to November 2017 audit, better than the C scored for patient centred care.

### Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 91.2%, which met the audit minimum standard of 90%. The 2016 figure was 82.5%.
The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 12.5%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 65.7%. This is within the expected range. The 2016 figure was significantly worse than the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 45.0%. This is within the expected range. The 2016 figure was significantly worse than the national level.

The one-year relative survival rate for the trust in 2017 is 27.1% This is worse than expected. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

Countess of Chester Hospital participated in the National Audit of Inpatient Falls 2017.

The crude proportion of patients who had a vision assessment (if applicable) was 17%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 10%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 21%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 89%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

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.

The consultants in the medical unit had a revalidation lead, and consultants would collate yearly evidence towards their revalidation which included; notes of achievements, concerns and complaints and how they had reflected on incidents.

Every Monday lunch time consultants from the medical units would attend a meeting to discuss a relevant educational topic. Recent lectures had been concerning; care of the elderly and a medicine programme. Junior Doctors would sometimes lead a topic and the consultants would critic the presentation.

Bank and agency staff attended a trust induction, however they did not receive a local induction when working on the medical wards.

Newly qualified medical staff received a six-month preceptorship with a mentor.
We spoke to the ward clerk on the frailty ward who had completed their mandatory training and specific training for administration, however they felt they needed training in conflict resolution as they sometimes dealt with aggressive and abusive relatives. They were told that only clinical staff received the training.

The stroke ward had recently initiated a one hour ‘rest period’ every afternoon for patients and the ward manager used this time for additional staff training and therapy staff trained the nurses on the ward.

The discharge lounge had a competent team with knowledge and additional skills. The two band four staff members working in the discharge lounge had both completed assistant practitioner qualifications and medication competencies and were able to complete tablets to take out (TTO’s) with patients on behalf of the pharmacy. The staff had also recently completed the NEWS 2 training and had cause to take patient’s blood pressure if they fell unwell.

Staff in the discharge lounge were also competent to remove cannulas if the ward staff had forgotten to remove them from patients.

Nursing staff told us that they were not always informed if a patient was diabetic, however they were competent to undertake their blood glucose reading and aware on how to escalate it.

The discharge lounge staff also told us that they were not made aware of a patient’s ‘Do not attempt pulmonary resuscitation’ (DNAR) status, even though they did accept end of life patients. Staff were not trained on thickener fluids and would ask a patient or member of ward staff to assist if required.

Staff on the stroke ward received specialist training from the stroke specialist nurse who held training sessions on the ward.

Specialist training in cardiac care for nurses on the Acute medical unit (AMU), monitoring cardiac patients was available via different resources. Cardiac specialist nurses held quarterly training days in which staff in AMU could attend. November’s training day saw 68 attendees. The cardiac specialist nurses visited AMU daily and staff could approach them at any time for education or advice and support. All new staff received training as part of Induction during their supernumerary phase. Training was also delivered via the consultant ward rounds at the central console where any anomalies from the previous 24 hours were discussed. Competency based learning packs covering the principles of the normal cardiac rhythm, cardiac monitoring & rhythm recognition, were available as a resource pack on AMU to support learning and trust nursing preceptorship programmes included sessions on electrocardiography recognition (the process of recording the electrical activity of the heart over a period of time using electrodes placed over the skin).

We spoke to a new member of staff on the coronary care unit and as part of their induction they had spent time in all the cardiology laboratories and departments in addition to shadowing cardiology specialist nurses.

The respiratory specialist care unit conducted staff training in-house. Training for tracheostomy and the use of cardiac monitors was cascaded down to staff from more experienced staff on the ward.

**Appraisal rates**

**The Countess of Chester Hospital**

From April to June 2018, 81.8% of staff in medicine at The Countess of Chester Hospital received an appraisal compared to the trust target of 95%. A breakdown by staff group is provided below:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to June 2018</th>
<th></th>
<th></th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>target</td>
<td></td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic and Technical staff</td>
<td>21</td>
<td>21</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>43</td>
<td>45</td>
<td>95.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>48</td>
<td>53</td>
<td>90.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medical and Dental staff</td>
<td>62</td>
<td>70</td>
<td>88.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>23</td>
<td>26</td>
<td>88.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>27</td>
<td>32</td>
<td>84.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>259</td>
<td>318</td>
<td>81.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing and health visiting staff</td>
<td>203</td>
<td>273</td>
<td>74.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>686</td>
<td>839</td>
<td>81.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust’s appraisal target was met by two of the nine staff groups within the medicine core service shown above, however it should be noted that the data only covers a three-month period.

The one nursing and midwifery staff member within medicine did not complete their appraisal; nursing and health visiting staff within medicine achieved an appraisal completion rate of 74.4%; and medical staff achieved an appraisal rate of 88.6%.

(Source: Routine Provider Information Request – Appraisals tab)

Staff were encouraged and given opportunities to develop. A personal development team was available for nurses. A leadership course was also available for staff and places were requested by the manager.

On ward 51 staff told us that study days were never refused and staff were always allowed to take them even if the ward was short staffed.

Managers on ward 50 and 51 told us that link nurses were being re-vamped, as the previous system had not been effective. Link nurses were now being recruited through volunteers. A list was under way on the wall of the unit for nurses to add their chosen area. Once complied, the link nurses would share good practice and changes in policy, procedure and guidelines with the rest of the team for that chosen area.

Multidisciplinary working

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

We attended a multidisciplinary ward round which included; a doctor, ward manager, therapist, memory nurses, specialist nurse, consultant and social worker. The meeting was consultant led and it was evident that all staff knew the clinical, emotional and social needs of the patient. Staff discussed the patient in a very caring manner. Other topics for the meeting were; patient communication needs, safeguarding concerns and safeguarding actions were re-iterated.

Monthly multidisciplinary meetings took place attended by consultants, ward managers, nurses, therapists and a full care of the elderly team to discuss staffing updates, concerns and ways to
improve patient care. Recently a meeting had discussed the importance of therapy for the patients on the medical wards and this led to all patients now being seen.

Regular multidisciplinary ward rounds took place on ward 50 and 51 with microbiologist, specialist nurse, consultant, pharmacist and the infection control team to look at managing CDIF.

The stroke unit had its own occupational therapist, physiotherapist, nurse and medics and daily intervention from the speech and language therapist.

The acute medical unit (AMU) were supported well by a multidisciplinary team, which included daily visits by; gastrointestinal doctor, respiratory doctor, cardiologist, physiotherapist and occupational therapist.

**Seven-day services**

Staff were available in the discharge lounge from 9am to 7pm, seven days a week. The unit was run by two band four assistant practitioners and three band two nursing assistants.

Throughout the medical division ward clerks were available supporting both staff and patients. The ward clerk on ward 48 was available 8am to 4.30pm five days a week.

The stroke unit had access to an occupational therapist six days a week.

The cardiac catheter suite was staffed between 8am and 6pm five days a week.

Ward 50 and 51 had access to a palliative care link nurse who had attended palliative care day four times a year. If the staff needed advice out of hours or at weekend they had a hospice line available to contact for symptom control and any concerns.

**Health promotion**

A package of care was available to respiratory in-patients enabling them to be discharged home early. The package entitled ‘Hospital at home’ was ran by designated nurses, with multidisciplinary input. When a referral was made the team would attend and access the patient on the ward and the final decision would be made by a Doctor. If the patient was suitable to early support discharge they would be seen at home by a nurse and a physiotherapist, where the patient’s statistics and chronic obstructive pulmonary disease (COPD) would be monitored.

The medical wards supported patients to manage their own healthcare, and wellbeing. On ward 50 and 51 we saw notices for patient’s family and friends encouraging them to provide comfortable day clothes and toiletries for the patients to encourage and promote independence.

The Coronary care had a number of information leaflets readily available for patients, including; pacemaker information, informing patients of expectations when leaving the hospital, information on implants and acute kidney information. The staff told us that when a patient leaves the ward they would go through the relevant information booklet one to on with the patient.

During our visit the tissue viability nurses ran a stand in the corridor of the hospital for ‘pressure ulcer awareness day’. Nurse came onto ward 50 and 51 and were making family and patients aware on pressure areas and how to avoid them.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

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.

On ward 50 and 51 there had been only the matron trained in deprivation of liberty safeguarding, however band seven nurses were now trained and more recently band five nurses. The wards also had a dedicated, full time band six mental health nurse who was a dementia specialist and was supported by a band five nurse.

We saw that on ward 50 and 51 the exit door release button within both wards was covered up with a piece of paper and was hard to find, staff told us that this was to prevent patients from leaving the ward. We checked patient records and found only two patients on a DOL’s; we spoke to the ward manager who removed the cover.

In 2017 the trust took part in a national audit of assessment and information standards for inpatients with cognitive impairment conditions, to integrate improvements for dementia care. The audit found that the majority of patients did not have a “This is me” document present although when this was present it was completed to a high standard. The audit highlighted deficits in three areas and advised the hospital to display posters in the areas around AED and AMU and in the corridors to inform relatives about the “This is me” form. Further staff training compliance was recommended and an amendment to the initial screening form.

For a patient to be placed in the medical escalation beds, consent was needed from the patients. An escalation check list had been implemented which included whether consent had been gained. We looked at two patients who were in the escalation beds and the question of consent had been marked as being obtained, however we spoke to a patient on ward 50 whose form had been completed, but they said they had not been spoken to as to being placed in the bed, nor had they given consent.

### Mental Capacity Act and Deprivation of Liberty training completion

#### The Countess of Chester Hospital

The trust set a target of 90% for completion of Mental Capacity Act (MCA) training. The trust informed us that this course encompasses deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA training from July 2017 to June 2018 for nursing staff in medicine at The Countess of Chester Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>276</td>
</tr>
</tbody>
</table>

The trust reported that from July 2017 to June 2018, Mental Capacity Act (MCA) training was successfully completed by 87.1% of nursing staff in medicine eligible for the training.

A breakdown of compliance for MCA training from July 2017 to June 2018 for medical staff in medicine at The Countess of Chester Hospital is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>85</td>
</tr>
</tbody>
</table>

The trust reported that from July 2017 to June 2018, Mental Capacity Act (MCA) training was successfully completed by 88.5% of medical staff in medicine eligible for the training.

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

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion; feedback from patients was positive and confirmed that staff treated them well and with kindness.

Patients told us that staff were ‘very kind, pleasant and couldn’t do enough for you’. Patients also confirmed they had access to call bells and that staff responded promptly and addressed the needs of patients when they were in pain or distress.

Interactions between staff, patients and relatives were overall, polite, caring and respectful. We observed engaging, friendly and encouraging interactions between staff and patients throughout the medical wards. Examples of this were; interaction between a ward manager and a patient living with dementia on ward 50, a healthcare assistant and housekeeper on ward 47 supporting the patient to eat and drink independently. We also observed a patient on ward 33 who had their hair cut and coloured by a hairdresser whilst on the ward, this patient told us that staff supported them to have this done.

However, one patient on ward 47 and one patient in the Endoscopy department told us that staff were at times ‘standoffish’ due to staff workload and at times felt ‘forgotten about’ and that staff didn’t always introduce themselves.

We observed that staff took the time to engage with patients and communicated in a caring way and considered the wishes of the patient, staff even knelt to speak at eye level with the patients. One member of staff commented that they ‘felt proud of the care the staff delivered’. A specialist dementia nurse had been employed on ward 50 and ward 51 and provided support to patients living with dementia, relatives and staff.

On the majority of medical wards we visited, patients had their privacy and dignity maintained, we observed interactions between staff, patients and relatives and staff treated people with privacy and dignity. Patients told us that curtains were drawn, and doors closed when treatments, examinations or nursing care were delivered. Confidentiality was respected in staff discussions between patients and those close to them, patients told us that staff spoke to people in a way that ensured people’s privacy and dignity was respected.

We observed that many of the wards we visited had received cards from patients and relatives, which thanked staff for the support and treatment and commented on the ‘compassion and patience’ of staff.

Staff on ward 51 bought birthday presents and cards for patients. A birthday party was ranged by staff for one patient who had wanted a birthday party and staff brought in the patients family and a cake. Staff had also allowed a family to hold a small wedding anniversary party on the ward for a patient who was too ill to leave the ward.
On ward 50 the doors to the patient toilets opened inwards and there was the ability for staff from the outside to open these outwards, which was necessary due to the poor design of the toilets. This then meant that the patient could be seen directly by people in the corridor and on the wards, meaning there was no privacy or dignity.

In the endoscopy unit signs ensured that patients’ privacy and dignity was maintained whilst booking into reception. A sign asked patients to wait a distance from the reception desk to prevent the queueing patients over hearing personal details.

Staff throughout the medical wards/units wore ID badges providing their name in accordance with the NHS campaign “Hello my name is…”

The discharge lounge offered donated clothes for patients who were discharged wearing a hospital gown or nightwear to keep them warm. Staff had also brought in colouring books, puzzle books and magazines to relieve the border for patients whilst waiting for transport.

The stroke ward had recently initiated a ‘rest period’ on the ward; 3.30pm to 4.30pm, where the lights were switched off, together with televisions and radios to enable patients to sleep or rest.

We spoke with 14 patients, who all gave us positive feedback about how staff treated and interacted with them. We spoke to a patient in endoscopy who told us that the staff were lovely and had explained everything to them and they had also assisted them to get changed.

**Friends and Family test performance**

The NHS Friends and Family Test (NHS FFT) is a satisfaction survey that measures patient’s satisfaction with the healthcare they have received. The results for the acute medical ward for October 2018 showed 84% of patients would recommend the unit to friends and family. September 2018 showed that 100% of patients who had attended ward 48, respiratory in-patients ward, were likely to recommend the ward to family and friends as a place to be treated. We saw this information displayed on the ward.

The Friends and Family Test response rate for medicine at Countess of Chester Hospital was 24% which was worse than the England average of 25% from August 2017 to July 2018.

A breakdown of friends and family test performance for medical wards at the hospital with a minimum of 100 responses from August 2017 to July 2018 is below. All but one the Medical Assessment United scored above 90% for the annual percentage of patients who would recommend the service.
Emotional Support

Staff provided emotional support to patients to minimise their distress. Patients consistently told us that if they became upset staff gave reassurance, one patient on Ward 33 commented that ‘staff take the time to sit and talk’, however one patient on Ward 47 with mental health needs told us they had not received the emotional support they required.

Staff and relatives both told us that visiting times were flexible to meet the needs of patients and those close to them.

The trust had a chaplaincy team who visited the wards daily and provided a 24 hour on-call service. The chaplaincy team consisted of four chaplains and 50 volunteers from four different Christian denominations and chaplains of other faiths were accessible via the team. The chaplaincy team offered support to all patients and staff with a faith and those with none. The spiritual care centre is on the first floor of the main hospital building and is open 24 hours a day. Patients we spoke to told us that their religious and spiritual needs were met, a member of staff from ward 50 told us that they had worked in conjunction with the mortuary staff and chaplaincy team to have a patient taken on their bed from the ward to the spiritual care centre to view the body of their deceased husband. Bereavement advice and support was available to relatives through the bereavement service.

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.

A member of Staff on ward 50 reported to us that patients and those close to them were invited to attend multi-disciplinary team meetings to discuss care and discharge plans. Patients consistently confirmed that they and their relatives were included in their care, one patient on ward 33 told us that they had been included in decisions and care had been individualised to their needs, and

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**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.

A member of Staff on ward 50 reported to us that patients and those close to them were invited to attend multi-disciplinary team meetings to discuss care and discharge plans. Patients consistently confirmed that they and their relatives were included in their care, one patient on ward 33 told us that they had been included in decisions and care had been individualised to their needs, and
relatives had been given physiotherapy exercises to do with the patient to help with their rehabilitation. We reviewed eight patient records and all showed evidence that patients and those close to them were involved in meetings and decisions about care.

We saw ‘this is me forms’ in use for patients living with dementia, forms were completed by the patient and those close to them and included information important to patients, staff used these forms to understand patients and individualise care and support.

Patients told us that staff explained their care and treatment to them in a way that they could understand, and patients felt they were always given enough time to ask questions. One patient told us that ‘processes were explained clearly’. We saw that staff communicated in ways that people could understand and took the time to answer questions. Staff had access to pictorial charts to facilitate communication with patients living with dementia and people with learning disabilities and one member of staff commented that they involved Speech and Language Therapists routinely to aid people to communicate.

Is the service responsive?

Service delivery to meet the needs of local people

The trust did not always plan and provide services in a way that met the needs of local people.

Patients from Welsh acute hospitals had a longer length of stay on ward 33 than other patients, due to there being no early supported stroke discharge for available for them provided by the Welsh Health Board.

In the discharge lounge we saw ‘message in a bottle’ available for patients to take home. The bottles are an effective way for medical and personal details to be located in an emergency.

Signage across the medical wards was not consistent and did not always meet the requirements for dementia patients, or patients with sight, or reading problems. On ward 33, (acute stroke and rehabilitation ward) we saw that some toilets had no pictorial sign and outside bay two the toilet was signed as a single sex toilet; however there was a pictorial sign showing a male and a female figure. On the same ward we saw that the sluice had no sign on the door and found it to be insecure.

We were told by managers on the acute medical unit that there were no links with community services, or social services and they no longer shared information if a patient from the community nurses had been admitted to the ward.

Average length of stay

The Countess of Chester Hospital

From June 2017 to May 2018 the average length of stay for medical elective patients at The Countess of Chester Hospital was 7.5 days, which is higher than England average of 6.0 days.

- Average lengths of stay for elective patients in clinical haematology and gastroenterology
were lower than the England averages.

- Average length of stay for elective patients in cardiology was higher than the England average.

**Elective Average Length of Stay - The Countess of Chester Hospital**

![Elective Length of Stay Chart]

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

For medical non-elective patients, the average length of stay was 7.7 days, which is higher than England average of 6.4 days.

- Average lengths of stay for non-elective patients in general medicine, geriatric medicine and cardiology were higher than the England averages.

**Non-Elective Average Length of Stay - The Countess of Chester Hospital**

![Non-Elective Length of Stay Chart]

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

**Meeting people’s individual needs**

In most cases the service took account of patients’ individual needs however, the escalation bed on ward 50 had caused patients who were allocated this space to complain.

We were told that one patient had not had their needs met due to their medical condition and staff had told us that it had been a challenge nursing them in the escalation bed, due to the position of the bed and lack of privacy curtains.

An escalation check list had been implemented in order to ensure the acuity of the patient admitted to the escalation bed. We looked at two patients who were in the escalation beds and the form had been completed and was found in the patient’s records. However, we spoke to a patient on ward 50 whose form had been completed, but they said they had not been spoken to as to why being placed in the bed or given any reason as to why.

Throughout the medical wards we saw various information leaflets available to patients and their families. On ward 48, respiratory in-patient’s unit we saw leaflets on; blood clots, domestic abuse, advise on slips trip and falls, patient advisory liaison service (PALS), walking aids and Macmillan
support and information care. In the discharge lounge leaflets were available on; life limiting illnesses, NHS transport service and slips trips and falls prevention.

All leaflets we saw were in English and staff were uncertain if they could obtain them in other languages.

If an interpreter was required by staff to speak to a patient the ward clerk would book one on admission. A language telecommunication line was also available and staff knew how to access it.

The tele-tracking system enabled packages of care to be displayed on the screen next to the patient number and bed. This ensured that all multi-disciplinary team staff were aware of what was required. The packages of care were numbered one to five, starting with one with the patient being able to be discharged home without change, to five; where the patient required a new placement. Other packages of care included palliative care with nursing support and rehabilitation support.

The medicine wards had access to the community rapid response teams and on discharge a referral was made to community teams and support was continued with ongoing cases.

There was a coronary care unit and a cardiology ward. The cardiology ward gave out leaflets to patient’s families with a list of contacts for their relatives’ consultants for them to contact through their secretary. The leaflet also contained information on what happened in the unit, the daily visiting times, protected meals times, rest period times for patient’s, practical information and names of the ward manager and sisters.

Patients on the cardiology unit (monitored) were informed, prior to being admitted, that due to the nature of the unit it was not always possible to segregate the male and the female patients, but the unit did their utmost to maintain the dignity of patients at all times. During our visit we saw that this happened.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

The tele-tracking system had improved patient flow to free up beds more quickly. Each patient wore a patient tracker which was activated once the patient wore the wristband. The co-ordination centre could see when a bed became available after a tracker was deactivated. The tele-tracking screens were available in the wards across the hospital. We saw one in practice and a capital ‘D’ displayed indicated that the patient was a potential for discharge, a ‘C’ meant that there was a confirmed discharge and ‘d’ meant that there was a query regarding discharge. When a bed space became available it turned green on the screen. We were told by managers and leads for medical wards that the system had improved access and flow and beds were empty for less time.

Managers told us that initial findings showed the time from a patient being discharged to their bed being ready for a new patient was now under two and half hours, which was down from approximately four hours.

The tele-tracking system also notified hospital when a patient needed moving from one area to another, we were told that initially this had been problematic and the response from porters was slow, with some patients waiting up to an hour to be moved, however, the tele tracking system was now work efficiently and overall porter requests to completion and been reduced by 23%.

Clinical site co-ordinators manged the bed flow using the tele-tracking system.
An audit of transfers from/between medicine wards after 10pm and 7am for November 2017 to October 2018 showed there had been 647 moves, the most moves occurred on the cardiac catheter suites; 130 and across all medicine wards most patients moved were between the hours of midnight at 1am. This did not include discharges and transfers to the discharge lounge.

The endoscopy only cancelled appointments when absolutely necessary, for example if a consultant was ill. If this happened the endoscopy administrative staff would contact the patient and they would be re-listed for the next available appointment. On occasions appointments were cancelled due to the patients’ blood pressure being too high, or there had not been adequate bowel preparation.

We were told there was currently a six week wait in the endoscopy unit, but the unit were attempting to get all patients through within four weeks. There were five procedure rooms in endoscopy but they were not all utilized due to the shortage of doctors in the unit.

The discharge lounge told us that delays for patient discharge was due to pharmacy delays and not enough transport. There was a 90-minute turnaround time for prescriptions to be made available; blister packs took longer therefore this caused delay. If the patient was delayed for more than four hours for their discharge, staff would record in as an incident on the reporting system. If the delay was due to pharmacy this would not get recorded in the discharge notes but would be reported by staff as a reason for delayed discharge on the system.

The cardiac catheter suite had recently started being used as an escalation ward, staff told us that this had impacted on the daily patient list for the suite. We were told of one incident where the manager had to cancel an angiogram for the day’s list as the beds were occupied by escalation patients who had been transferred in the night. The patients in the escalation beds were reviewed for discharge at 9am by the pharmacist and consultant, however the patient list for the day in the cardiac catheter suit starts at 8am. We spoke to the leads regarding this who confirmed that it was a last resort to use the cardiac catheter suite as an escalation ward.

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

From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was better than the England average.

![Graph showing referral to treatment (percentage within 18 weeks) - admitted performance](image)

(Source: NHS England)

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

From August 2017 to July 2018, all six applicable 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></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Managers from the Medical assessments unit (AMU) told us that a theme from their complaints was regarding communication. They shared learning from complaints and fed back to staff at the daily safety briefs. The safety brief was a verbal meeting between managers and the registered nurses and assistant nurses. A paper copy of the safety brief was retained and stored in a folder to refer to.

The top complaints which were made to the medical departments were all in regard to waiting times; to be seen, to see a doctor, for a bed and to be streamed. All medical department devised actions plans and shared learning across the wards and if appropriate across the wider division.

During our visit we looked at complaints on ward 50 and were told that there had been no formal complaints for the ward in the past 12 months. If a complaint was made it was dealt with at a local level and escalated to a more senior staff member if not resolved.

Summary of complaints

The Countess of Chester Hospital

From 26 July 2017 to 25 July 2018 there were 50 complaints about medicine.

The trust took an average of 34 days to investigate and close complaints. This met the trust target of closing complaints within 40 days.

The table below shows the complaints broken down by subject:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>27</td>
<td>54.0%</td>
</tr>
<tr>
<td>Communications</td>
<td>6</td>
<td>12.0%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>4</td>
<td>8.0%</td>
</tr>
<tr>
<td>Appointments</td>
<td>4</td>
<td>8.0%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to the absence of a care package)</td>
<td>3</td>
<td>6.0%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
<td>4.0%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
<td>2.0%</td>
</tr>
<tr>
<td>Staff values &amp; behaviours</td>
<td>1</td>
<td>2.0%</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>1</td>
<td>2.0%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>2.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: NHS England)
Number of compliments made to the trust

The Countess of Chester Hospital

From 26 July 2017 to 25 July 2018 there were 42 compliments received about the medicine core service at the hospital.

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

All staff said the team leads and ward managers were supportive regarding any issues on the ward. We were told that they were very visible on the wards and had good leadership skills.

We were told by the service leads that managers were now working clinically at weekend in order to support staff and reduce the number of staff moves.

The ward managers told us they had access to leadership and management training.

Doctors told us that senior medical staff were accessible and they received good support and understood their commitments to the general medical council (GMC).

We observed positive working relationships within all teams. Staff we spoke to said they had received their annual appraisal.

Ward 42, cardiology ward was linked to the coronary care unit and managed as part of one team and managed by one ward manager. We were told by staff that this had integrated the teams to work more efficiently and as one unit.

Vision and strategy

The trust 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 coronary care unit (monitored) had the unit’s philosophy displayed in the ward, it highlighted the staff priorities for the patients as being, comfort and wellbeing and to provide a calm, peaceful and reassuring environment, meeting physical and emotional needs. When we visited the unit, we felt that the environment was calm and peaceful.

The recruitment and retention workstream were looking at ongoing recruitment and had arranged recruitment fayres and recruitment drives. Relationships were also ongoing with Welsh Universities and they were now sending students who the medical services hoped to retain. In October the medical service had 46 vacancies’ and it had now been reduced to 22. The vision was to be fully staffed by March 2019.
Due to the shortage of registered general nurses, pharmacists were to support with ward medications.

We were told that the high number of transfers from/between medicine wards after 10pm and 7am was set to reduce as the electronic tracking system is further embedded, it was believed that improved compliance of ensuring the right patient gets to the right bed at the right time will become more evident.

**Culture**

Morale was poor between staff on the medical wards, staff felt supported by local leaders, however senior managers did not promote a positive culture and staff told us that they felt unsupported and undervalued.

We were told that the morale was mainly down to staff being moved. Some nurses were not informed that they were being moved areas until attending for their shift. We spoke to some managers who did try and pre-warn staff if movement was necessary prior to their shift, and they received good feedback from this. Nurses were sometimes moved to areas they were unfamiliar with and did not receive an induction or familiarisation visit, this caused anxiety amongst some nurses.

Staff we spoke to had all experienced being moved areas to work. They told us that this had become a regular occurrence and was now normal. Some managers informed staff prior to their shift that they were being moved and this prepared the staff member. We were told that on some occasions, staff remaining on their usually working ward had been left feeling they were in an unsafe staffing position due to the acuity of the patients.

Ward 54 was used as an escalation ward and staff told us that they feared being moved to cover on this ward. They said that it was mainly staffed by bank and agency staff, it was not stocked efficiently with equipment and did not have access to a pharmacist or junior doctor. These concerns caused low morale and lack of any team work.

We spoke to managers in the stroke unit who also put poor moral down to staff moves and said that the last 12 months moral had been really low amongst their staff, but also blamed staff shortages.

Managers on ward 50 and 51 had planned cross covering of staff for rotas, in order for all members of the team to attend a Christmas party this year, to help improve morale. The same managers also held open door sessions for staff on Wednesday evenings to combat moral and answer and questions, or worries staff had.

All the staff we spoke to during our visit did not know why they wore a personal tracking card linked to the tele-tracking system. The reason for the need for staff to wear the devices had not been communicated to them. Some believed it was to track their whereabouts and some said it was to see how many times they had approached a patient. This insecurity by staff also effected morale.

The escalation beds found in a number of medical wards had caused problems for staff as well as patients. Staff told us that they had received verbal abuse from patients and their families who had been admitted to the escalation beds. Staff told us that patients were not consenting to being in the beds before being allocated causing hostility.
Many of the managers and leads we spoke to talked of ‘Good will’ stating that it was the good will of staff that overcame the problems with wards being short staffed.

**Governance**

The trust approach to continually improving the quality of its services was not always effective. The service leads told us that over the last six to eight months the governance structures were being reviewed as a result of staff feedback. They intended to change the structure to support improvement on governance.

A ‘What’s brewing’ open door session was held between 8am and 9am in the staff canteen where a member of the executive team was present in order for staff to approach and ask questions or share concerns. We were told that a group of managers had attended the session one morning to express their concerns over the shortage of registered general nurses, however they were not given any formal feedback.

We were told by staff that it was very rare to see any of the leadership team. The chief executive had however been visible visiting the medical wards approximately a month before our visit.

The tele-tracking system was brought to the hospital in January 2017 to provide the trust with a ‘global view’, ‘tracking the patient’s journey from front door to back door’. Staff understood the purpose of the tags that patients wore and could explain how equipment was tracked, however not one member of staff we spoke to (of all grades) understood why they were wearing readable tags. Comments made by staff were; “It’s there for a reason, we just don’t know the reason”, “To see how long we spend on a break”, “Not sure why I was wearing it, so now I don’t bother”.

The trust reported that information leaflets and staff briefings were provided for staff about the tele-tracking staff badges however, Staff on the medical wards told us they had not been communicated with as to the reason they were wearing the tags. Some staff described the system as ‘Big brother’ and were concerned at being monitored, others had been informed that the tags were for their own security and the red button on the tag could be pressed in the case of an emergency. We were told the tags were not programmed for this.

During our visit we saw two tele-tracking screens that were not working; on ward 48 and on the endoscopy unit, staff on ward 48 told us that the screen was frequently not working.

**Management of risk, issues and performance**

The trust did not always have effective systems for identifying risks, planning to eliminate or reduce them.

We saw that the risk register identified risk, but there was no effective monitoring or, action plans as a result. For example, we saw that the defective call bells in AMU had been on the risk register for two years and the risk had been downgraded without any progress. Clinical leads told us that risks would be reviewed as part of their new governance structure and new quality and safety meetings.

Systems for identifying risk were not effective and Sepsis and NEWS processes had not been fully implemented.

The temporary escalation bed on some medical wards posed a risk to patients, staff and visitors. The decision to place the beds in front of fire exits had been done with risk assessment and fire
service input however, there was evidence to say that the beds were not temporary as the bed escalation policy had stated.

There was ward level, divisional and corporate risk registers across the trust. Staff at all levels knew that there was a risk register and senior managers were able to tell us what the key risks were for their area of responsibility. Each risk had the date the issue was raised and the review date however, there was no named assigned person, no date for completion of the action and no plans of actions were recorded. We were told that risk could effectively remain on the risk register indefinitely.

The consultants for the medical unit attended a weekly radiology multidisciplinary meeting where cases with unusual findings were discussed. The meeting allowed a clinical discussion and sharing of good practice to improve processes.

Every Friday the ‘Hospital ground round’ took place, a full hospital meeting attended by medical managers, consultants as well as other departmental leads where risks, issues and mitigating actions were discussed.

The stroke unit told us that there three top risks were; falls, staffing issues and pressure ulcers. Their aim was to reduce falls and pressure ulcers. However, staffing was down to a number of vacancies which could not be filled, due to a shortage of nurse to recruit, not for financial reasons.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

We saw that results from audits of the tele-tracking system were displayed intermittently on the home screen of each computer on the medical wards, for staff to read. These were called ‘Fast facts’. An example of ‘Fast facts’ displayed at the time of our visit were; patient breaching in four hours, down by 78%. Patients admitted to the wrong bed had been reduced by 48%.

**Engagement**

Overall the trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

However, we were told by the leads that the relationship with the Clinical commissioning groups (CCG’s) fluctuated daily. We were told this was due to the turnover of commissioners and because the trust was on a bock contract. Working together with the CCG’s was described as a ‘challenge’ and that it didn’t include ‘growth and demand’.

Medical wards had started their own closed social media page in order to communicate with each other and managers posted non- clinical information to staff.

A staff meeting was held every four months, for ward 50 and 51 which was open to all staff on the wards, however, historically it had been poorly attended. Recently the managers had taken in breakfast to encourage staff to attend.

Patients on medical wards were encouraged and had access to various opportunities to give feedback about their care or experience at the hospital for example on the bedside TV screens, friends and family test, inpatient experience survey and via social media, all of which could be accessed via the hospitals’ website.
All patients we spoke to had made comment to how well they had been kept informed at every staff of their path and felt involved in all decisions.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The emergency multidisciplinary unit (EMU) was a new initiative set up approximately three months prior to our visit. The unit comprised of a geriatrician, senior Doctor, advanced nurse practitioner and therapists. The aim of EMU was to access patients quickly and diagnose the patient’s condition and where ever possible treat them the same day so that they could return home, with the right help and medication. The team attended at the accident and emergency department and referred patients to the unit. Staff were also able to make referrals to EMU, as were GP’s who were able to make direct referrals.

Ward meetings were held on ward 50 and 51 every three months which the ward manager and matron attended. Improving patient care was discussed at the last meeting. The meeting was minuted and shared for those staff unable to attend.

There were few systems to support improvement and innovative work. An acknowledgment of outstanding work was through the trust GEM awards, which was awarded to staff, by staff and the winners were rewarded with a team lunch.

Staff were able to thank each other for by submitting positive comments via the intranet, which were then displayed on a ‘wall’ on the intranet.

Annually the trust held a celebration of achievement awards for staff. Recently the tele-tracking system had earn the trust a national award for using information technology to ensure that the patient gets the right bed in the right speciality.

Staff and patients had been fundraising to make improvements to the frailty wards. There had been a small patient day room, however rooms off this were used by the multidisciplinary team and a doctor’s office, therefore was not a suitable environment for patients to relax. There was also nowhere for family and friends to wait. Fundraising had enabled work to begin on transforming the rooms to a large day room.

A second phase of improvements on the frailty ward was planned, entitled ‘Creating memory lane’. The vision was to enhance the environment by creating an interactive corridor for the elderly, improving the lighting and décor on the main wards, creating privacy pods and to develop a sensory garden.

The ward manager on the stroke unit emailed all staff on the ward if an incident had been investigated and lessons learnt. Any learning from incidents was also discussed at the daily and weekly safety huddle, as it was across all areas of the medical wards.
Surgery

Facts and data about this service

The surgical core service at the trust has 161 inpatient beds over six wards:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 40 - Breast and plastics care</td>
<td>29</td>
</tr>
<tr>
<td>Ward 41 - Orthopaedic joint surgery</td>
<td>29</td>
</tr>
<tr>
<td>Ward 44 - Colorectal care</td>
<td>28</td>
</tr>
<tr>
<td>Ward 45 - Upper and Lower GI surgery</td>
<td>21</td>
</tr>
<tr>
<td>Ward 52 – Trauma and orthopaedics</td>
<td>28</td>
</tr>
<tr>
<td>Ward 53 - Vascular surgery</td>
<td>26</td>
</tr>
</tbody>
</table>

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

The surgical division (planned care) provides elective and emergency care in a range of clinical specialties including; trauma and orthopaedics, general, colorectal and upper GI surgery, urology, ear, nose and throat, ophthalmology, oral and maxillo-facial and orthodontics, breast, plastics, nephrology and vascular surgery.

The Division includes an elective ward, trauma ward, two surgical wards which include colorectal cancer and vascular ward and a surgical assessment unit (SAU).
Theatres comprise of 11 inpatient theatres, (10 in use), a recovery area and a theatres admission lounge. The Jubilee Day Case Centre has four day-case theatres, a theatre for local anaesthetic procedures, a recovery ward and the pre-operative assessment clinic.

The trust is the provider for vascular and arterial surgery for the South Mersey region. It provides seven-day consultant led services encompassing elective and emergency surgery, two dedicated theatres including an emergency/urgent theatre, dedicated 26 bedded inpatient unit and delivers day case surgery across three trusts in the network; Chester, Wirral and Warrington.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

The trust had 29,869 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 6,282 (21.0%), 21,099 (70.6%) were day case, and the remaining 2,488 (8.3%) were elective.

(Source: Hospital Episode Statistics)

The surgical services at the Countess of Chester Hospital are managed by the surgery, critical care and anaesthesia division. This included the operating theatres, the surgical wards, the surgical assessment unit and the pre-operative assessment clinic.

The Care Quality Commission (CQC) carried out an unannounced inspection between 13 and 15 November 2018, that is staff did not know we were coming, to enable us to observe routine activity. During this inspection we visited surgical wards 40 (Breast and plastics), 41 (orthopaedics), 44 (colorectal), 45 (gastrointestinal), 52 (trauma and orthopaedics), 53 (vascular), the surgical assessment unit, pre-operative assessment clinic, the theatres admissions lounge, the operating theatres, recovery areas and the day case unit.

We spoke to 16 patients and relatives. We also spoke with 40 members of staff including senior managers, specialist nurses, registered nurses, student nurses, health care assistants, consultants, middle grade doctors, junior doctors, medical students, allied health professionals including physiotherapists, occupational therapists, dieticians, pharmacists, domestics, ward clerks, housekeepers and nursing agency staff.

We observed care and treatment and looked at 22 patient care records. We reviewed comments from staff focus groups, patient feedback cards and we looked at the service performance data.

Is the service safe?

Mandatory training

Mandatory training completion rates

The Countess of Chester Hospital

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

A breakdown of compliance for mandatory training courses from July 2017 to June 2018 for qualified nursing staff in surgery at The Countess of Chester Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>209</td>
</tr>
</tbody>
</table>
In surgery the target was met for one of the eight mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from July 2017 to June 2018 for medical staff in surgery at The Countess of Chester Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>118</td>
<td>121</td>
<td>97.5%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>113</td>
<td>121</td>
<td>93.4%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>113</td>
<td>121</td>
<td>93.4%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>113</td>
<td>121</td>
<td>93.4%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>113</td>
<td>121</td>
<td>93.4%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>113</td>
<td>121</td>
<td>93.4%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>113</td>
<td>121</td>
<td>93.4%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>104</td>
<td>121</td>
<td>86.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the target was met for one of the eight mandatory training modules for which medical staff were eligible.

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

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The surgical division followed the trust mandatory training policy. This was based on a training needs analysis which determined which training staff were required to undertake based on their roles and responsibilities. Staff were required to undertake a range of general and role specific mandatory training modules in line with the policy and the mandatory training schedule. This also set out the frequency that each module was to be repeated. The majority of these courses were undertaken electronically. Some training such as life support training required attendance in person in a classroom.

During our inspection we sampled a number of wards and areas and found that ward and theatre managers kept a record and monitored their team’s compliance with mandatory training. We found that any pockets of non-compliance were largely amongst staff members who were on long term sick absences. The trust had a good system for alerting individuals and managers when mandatory training was due.

**Safeguarding**

Safeguarding training completion rates
The Countess of Chester Hospital

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

A breakdown of compliance for safeguarding training courses from July 2017 to June 2018 for qualified nursing staff in surgery at The Countess of Chester Hospital below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
<th></th>
<th></th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>181</td>
<td>210</td>
<td>86.2%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>176</td>
<td>210</td>
<td>83.8%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 and 2</td>
<td>162</td>
<td>210</td>
<td>77.1%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the target was not met for any of the three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from July 2017 to June 2018 for medical staff in surgery at The Countess of Chester Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
<th></th>
<th></th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>112</td>
<td>121</td>
<td>92.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>108</td>
<td>120</td>
<td>90.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 and 2</td>
<td>67</td>
<td>121</td>
<td>55.4%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the target was not met for any of the three safeguarding training modules for which medical staff were eligible.

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

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Although staff had training on how to recognise and report abuse, some staff caring for children in the Jubilee Day Surgery Unit and in theatres recovery were not training to level 3 safeguarding children and young people.

A safeguarding policy was in place which was in date and accessible to staff. Staff we spoke with could explain what they would do if they had a concern about a vulnerable adult or young person and they understood the correct process to follow. We saw algorithms on notice boards advising staff what to do regarding concerns identified in core hours and outside core hours. Safeguarding vulnerable adults and safeguarding children and young persons was included in the hospital mandatory training programme.

The trust had a safeguarding team and a safeguarding specialist nurse. The trust safeguarding team was available during core hours for staff to contact should they have any safeguarding queries or concerns.

Paediatric surgery was undertaken in theatres. We saw a designated children’s recovery bed which had curtains around and bright decorations. We were told that children were listed for their procedures on an ad hoc basis and there were no dedicated paediatric theatres lists. There were also some unplanned emergency paediatric surgery which was undertaken as necessary. The Jubilee day surgery unit treated children from 14 years old and the wards cared for young people.
aged 16 and 17 years on the adult surgical wards. No staff in these areas were trained to level 3 in safeguarding children and young persons. This was not in keeping with intercollegiate guidance. The trust had deemed that these staff were to receive training to level 2. Staff did know what to do and if they had a concern about safeguarding they could consult the paediatric ward where there were nurses trained to level three and four. They also had access to the child safeguarding team who could advise them accordingly.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

We observed that clinical and surgical areas appeared visibly clean. Cleaning was undertaken by an external contractor. Cleaning rotas were in place and these were audited regularly. Staff said if there were any areas of concern they would clean these themselves.

An infection prevention and control policy was in place and we found staff were aware of this policy. There was an infection prevention and control team in the hospital with infection control specialist nurses. These were available as a point of contact for advice, guidance and training.

We observed that staff working in clinical and surgical areas were compliant with the trust uniform policy and arms ‘bare below the elbow’ practice. Alcohol gel points and hand washing sinks were available around the clinical areas for the use of staff, patients and visitors. There was access to hand gels and handwashing facilities for staff at the point of care and we observed these to be utilised as appropriate by staff and visitors.

During our inspection we observed that staff cleansed their hands between patient contact and before and after performing care interventions. Staff on wards used personal protective equipment, such as gloves and aprons as appropriate. Staff in theatres followed infection prevention precautions and wore appropriate theatre attire in designated areas.

Those patients who were subject to isolation precautions due to infection or at risk of infection were cared for where possible in single side rooms. However, some side rooms did not have doors and others were left open. There was appropriate signage to indicate that the patient was subject to isolation precautions. Access to personal protective equipment was in place.

The latest surgical site infection annual audit report was published December 2017, which is the latest published data and covered the period April 2016 to March 2017. The trust recorded no surgical site infections for hip replacements, from 83 operations. This was better than the England average. The trust recorded no surgical site infections for knee surgery from 67 operations, this was better than the England average. The trust recorded one surgical site infection neck of femur repair from 183 operations, this was better than the England average.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well. However, some fire escapes were not usable and some substances hazardous to health were not stored safely.

The premises were suitable and maintained in most areas within the division. However, the fire escapes on some wards had been blocked by patient beds, desks or other equipment so as to prevent the fire escapes being accessible in the event of an emergency. Staff stated they had expressed their concerns about the safety of this practice and about the privacy and dignity issues of those patients in those beds. Some staff said they had raised their concerns to their managers.
and the trust fire lead. The trust stated this was a temporary issue and they were used for escalation purposes however, we found that this practice had been in place for some time. The trust stated they had risk assessed these practices with the local fire service, however we did not see evidence that this was the case.

In the operating theatres staff told us they had access to the equipment and instruments they needed to undertake their roles. The division used single-use, sterile instruments as appropriate. The single use instruments we saw were within the manufacturers’ expiry dates.

The service had arrangements for the cleaning and sterilisation of reusable surgical instruments which were undertaken on site by the Hospital Sterilisation and Decontamination Unit. We were advised that there was an efficient turnaround of equipment and an urgent service was also available. Within theatres there was a robust process for ensuring clean and dirty items were segregated to reduce the risk of any cross contamination.

Waste and clinical specimens were handled and disposed of in a way that kept people safe. Staff used the correct system to handle, sort and store different types of waste and these were labelled appropriately.

Resuscitation equipment was checked in line with trust policy. Trolleys were sealed and a record was kept of unique seal reference numbers. During the inspection a sample of items contained within the trolleys were checked and were found to be in a useable condition and within the manufacturers’ expiry dates.

Medical and clinical equipment was serviced and tested regularly. The medical engineering department provided maintenance and engineering services to the hospital and was responsible for the periodic servicing and maintenance of trust equipment. The sample of equipment we checked had been serviced and checked appropriately. Operating theatres had their air circulation annual checks completed annually as appropriate we saw that the systems met minimum requirements for safe use during the last service dates for 2018. Bariatric equipment was available to the wards and theatres if required. Operating theatre tables were suitable for use by bariatric patients and were labelled accordingly.

However, during our inspection, we found items subject to the 'control of substances hazardous to health' regulations were not stored securely and according to guidelines. We saw that chlorine cleaning tablets were not locked away and could be accessed by unauthorised persons.

**Assessing and responding to patient risk**

Staff did not always do all that was possible to reduce the risk to patients. This was due to lapses in processes and knowledge in key areas.

The division used a recognised ‘track and trigger’ scoring system for recognising acutely ill and deteriorating patients. They used an early warning system to identify patients who were most at risk of deterioration and aid the escalation of their care. The patient’s observations and vital signs produced a score, which correlated with certain actions such as urgent medical attention or greater frequency of observations. During the inspection a sample of charts were checked and we saw these had been escalated as appropriate. Staff we spoke with were familiar with the triggers and what action to take.

A critical care outreach team was available 24 hours a day, seven days a week. The team responded to clinical emergencies and those patients requiring immediate attention or triggering an urgent response on their early warning score, due to their clinical observations.
Patients’ risk during surgery was assessed at pre-operative clinic which was a nurse led service. The assessment nurses took the patient’s past medical history, undertook a clinical examination and determined if any further tests or information was needed prior to surgery. The pre-operative clinic also had some designated anaesthetist led appointments for those patients who were potentially at greater risk and who needed a consultation with an anaesthetist prior to their surgery. The pre-operative team initiated enhanced recovery protocols for relevant procedures and educated patients on the programme and what they needed to do. The pre-operative clinic also assessed patients for their mental health needs and any phobias or anxiety.

During our inspection we found there was an inconsistent approach to assessing a patient’s risk of developing complications or experiencing harm during their treatment. We saw that whilst some questions were asked around falls, this did not lead on to further, more detailed assessment or the implementation of falls reduction care plans. We also found that it took a patient to actually fall before additional measures were taken such as enhanced supervision was implemented or any other falls reduction measures. We found there were limited falls reduction processes available to reduce the risk of falls. We also saw that the division had reported that patients in their care had experienced ‘unwitnessed falls’. Staff we spoke with stated that this was largely associated with staffing levels as there were insufficient staff to closely monitor such patients and that increased monitoring would only be available if the patient had already fallen. The practice of undertaking falls assessments but this not leading to mitigation of risk was also seen in analysing investigations and reviews following incidents of falls. The investigations looked into the fact that assessments had been undertaken but did not identify measures that should have been in place to mitigate risk. The trust had specified in its quality improvement plans for 2018 to 2019 that it would be implementing a falls prevention initiative that would be rolled out during the year to April 2019. This had not yet been embedded and has the potential to improve some of the issues we identified on inspection.

We saw that other risk assessments such as nutritional needs, risk of falls and mobility, venous thromboembolism (VTE), manual handling, skin integrity and risk of pressure ulcers were undertaken, but documented care plans were not always implemented as a response to the identified risk. We also found that other risks such as a patient living with dementia or a learning disability or patients with diabetes, or those needing help with mobility or eating and drinking were also not highlighted effectively. We were advised that these risks were highlighted at handover and were familiar to staff as they “knew their patients”, however, some staff involved in the care of patients such as domestics, care and comfort staff or allied health professionals may not have been involved in the handover process and may not be fully aware of a patient’s needs. The electronic patient record had some symbols which could aid awareness of patient risk, however we found that this facility was not being used on many wards and that some staff did not have access to this system. Furthermore, where alerts were attached staff were not always familiar with what the symbol meant and gave differing responses to what the symbols indicated.

Emergency pull cords were available in areas where patients were left alone, such as toilets and changing areas. Call bells were available on wards and we saw that these were placed within reach of patients’ hands to help make sure they could access help should it be required.

During our inspection we found varied knowledge, training and application of sepsis care. We found that on one ward (ward 44) knowledge around sepsis was good, we learned that this ward had received some training as it had been a pilot ward for the sepsis project implementation programme. However, on other wards we found that staff did not understand the triggers for sepsis and how they fitted in with early warning scores.
During our inspection we observed the operating theatres processes around the National Patient Safety Agency ‘five steps to safer surgery’ and the completion of the World Health Organization (WHO) checklist. We observed a range of processes in different operating theatres, with different staff. Although we observed some good practice with some of the processes such as pre-operative checks, briefings and debrief. We found inconsistent compliance with other aspects of procedure such as ‘sign in’, ‘time out’ and ‘sign out’ parts of the checklist. The World Health Organization guidance was fragmented and not followed to a satisfactory standard with omissions in some processes and lack of adherence to principles. The relevant staff were not always present at the appropriate times and there was a lack of engagement from the whole team at vital times in the process. We observed that a single member of staff undertook some checks with other staff not participating, which meant it was not a collaborative process. We also observed that ophthalmology implants were not checked prior to insertion. The division supplied data that showed internal audits of the World Health Organization checklist were undertaken. This showed that the division had reported themselves to have good compliance, in excess of 99%, with processes during the latest audit from April to June 2018.

We were told by managers that there were plans in place to undertaken ‘human factors’ training in the future which may assist strengthen theatres safety process.

The operating theatres team had a rolling half day ‘audit day’ whereby the theatres team had time set aside where no surgical activity was carried out in order to undertake audits and internal reviews of performance, training and improvement initiatives for staff.

During our unannounced inspection, it was evident that the surgical division had implemented their own ‘Local Safety Standards for Invasive Procedures’ (LocSSIPs) based on the ‘National Safety Standards for Invasive Procedures’ (NatSSIPs). This was a directive by the National Patient Safety Agency (NPSA) which instructed hospitals to implement plans to standardise processes and improve the safety of higher risk invasive procedures.

### Nurse staffing

#### Planned vs actual

**The Countess of Chester Hospital**

The trust has reported their staffing numbers for nursing staff within surgery at The Countess of Chester Hospital below for the period April to June 2018.

<table>
<thead>
<tr>
<th>Department / ward name</th>
<th>Actual staff (WTE)</th>
<th>Planned staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient pre-assessment</td>
<td>4.9</td>
<td>4.0</td>
<td>121.7%</td>
</tr>
<tr>
<td>Theatres</td>
<td>83.6</td>
<td>80.0</td>
<td>104.6%</td>
</tr>
<tr>
<td>General surgery</td>
<td>18.3</td>
<td>18.0</td>
<td>101.4%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>1.0</td>
<td>1.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Surgical wards</td>
<td>68.0</td>
<td>70.0</td>
<td>97.1%</td>
</tr>
<tr>
<td>Surgical wards 2</td>
<td>19.3</td>
<td>20.0</td>
<td>96.4%</td>
</tr>
<tr>
<td><strong>Surgery total</strong></td>
<td><strong>195.0</strong></td>
<td><strong>193.0</strong></td>
<td><strong>101.0%</strong></td>
</tr>
</tbody>
</table>

Three of the six departments/wards were listed as being over-established.
Vacancy rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a vacancy rate of 3.5% for nursing staff in surgery at The Countess of Chester Hospital. The trust reported no vacancy target.

Turnover rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a turnover rate of 18.3% for nursing staff in surgery at The Countess of Chester Hospital; this was higher than the trust target of 10%.

Sickness rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a sickness rate of 4.9% for nursing staff in surgery at The Countess of Chester Hospital; this was higher than the trust target of 3.65%.

Bank and agency staff usage

The Countess of Chester Hospital

The table below shows the numbers and percentages of hours in surgery at The Countess of Chester Hospital from July 2017 to June 2018 that were covered by qualified nursing bank and agency staff or left unfilled by department.

<table>
<thead>
<tr>
<th>Ward / unit name</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>Not filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Ward 41</td>
<td>12,344</td>
<td>5,193</td>
<td>42.1%</td>
<td>1,310</td>
</tr>
<tr>
<td>Theatre recovery</td>
<td>11,121</td>
<td>737</td>
<td>6.6%</td>
<td>2,284</td>
</tr>
<tr>
<td>Ward 53</td>
<td>8,001</td>
<td>2,124</td>
<td>26.5%</td>
<td>550</td>
</tr>
<tr>
<td>Ward 52</td>
<td>7,092</td>
<td>418</td>
<td>5.9%</td>
<td>444</td>
</tr>
<tr>
<td>Ward 44 Bridge Ward</td>
<td>7,038</td>
<td>3,754</td>
<td>53.3%</td>
<td>1,482</td>
</tr>
<tr>
<td>Ward 45 Palace Ward</td>
<td>6,989</td>
<td>305</td>
<td>4.4%</td>
<td>458</td>
</tr>
</tbody>
</table>
The trust also indicated that within the Jubilee escalation unit, 12 hours were covered by bank staff, 28 hours were covered by agency staff and a further 89 hours were unfilled. Data for this unit is not included in the above table because the total numbers of hours available for all staff was not provided by the trust.

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

The service did not always have enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

During our inspection we were told that nursing and support worker staffing was a challenge on some wards. Although staffing fill rates percentages show established staffing numbers were satisfactory, other data shows actual care hours per patient were always significantly less than that the required levels during October 2018. There was high use of bank and agency staff on some wards in particular on wards 41, 53 and 44. It also showed that even with the high percentage of bank and agency staff, there were still significant numbers of shifts that remained unfilled.

<table>
<thead>
<tr>
<th>October 2018</th>
<th>Ward</th>
<th>Actual care hours per patient</th>
<th>Required care hours per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>5.9</td>
<td>6.2</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>5.2</td>
<td>6.3</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>5.3</td>
<td>6.8</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>6.5</td>
<td>7.4</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>6.2</td>
<td>6.9</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Trust Website Data)

The hospital had regular bed meeting to assess staffing levels and used the safety care tool as a means of assessing safe staffing levels. There was also a pool of nursing staff who would be allocated where there was the greatest need or to staff escalation areas. Staff we spoke with told us that they often felt stretched due to the acuity of patients and due to them sometimes having to provide one to one care for patients. They said that established staffing levels were sufficient at times but at other times they may not be. They felt that acuity of patients was not always catered for when allocating staff. We were also told that staff were sometimes taken away to cover other wards in the hospital and this left some wards down on their staff numbers. We were told that staff do no always submit incident reports around staffing levels as it has become the norm that staff miss their breaks and work beyond the end of their shifts.

We did however receive details of some red flag staffing incidents that had been reported in the last three months. These indicated that wards 41, 45 and 53 had reported incidents around staffing in the last three months, these were also the wards that had the highest vacancies and greatest bank and agency staff use. Staffing fill rates for ward 41 in October were 78%. During our inspection we found there were some avoidable incidents reported that staff claimed to have been
due to staffing levels. We examined some investigations and reports of patient incidents which had been reported, these supported the notion that staffing issues had contributed to the occurrence of such incidents.

We found that it was planned that surgical wards had two registered nurses on at night to cover 28 patients, this was sometimes covering immediate post-operative patients who required more close attention, which staff felt was sometimes a challenge. We were also told that on some occasions one of the registered nurses was taken to cover another area and during those times there was no other nurse to check controlled drugs and intravenous medications. Staff told us this caused delays in responding to the needs of patients. However, despite being told this by a number of staff on different wards, data from the trust did not support that this was common practice and we were advised that this had occurred on only one occurrence in the six months before the inspection.

**Surgical staffing**

**Planned vs actual**

**The Countess of Chester Hospital**

The trust has reported their staffing numbers for medical staff within surgery at The Countess of Chester Hospital below for the period April to June 2018.

<table>
<thead>
<tr>
<th>Department name</th>
<th>Actual staff (WTE)</th>
<th>Planned staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral maxillofacial</td>
<td>4.0</td>
<td>4.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>2.0</td>
<td>2.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>11.6</td>
<td>12.0</td>
<td>96.7%</td>
</tr>
<tr>
<td>General surgery</td>
<td>35.6</td>
<td>38.0</td>
<td>93.7%</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>41.7</td>
<td>45.0</td>
<td>92.6%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>16.8</td>
<td>19.0</td>
<td>88.2%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>6.7</td>
<td>9.0</td>
<td>74.7%</td>
</tr>
<tr>
<td><strong>Surgery total</strong></td>
<td><strong>118.3</strong></td>
<td><strong>129.0</strong></td>
<td><strong>91.7%</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

The service had enough surgical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

During our inspection we found that surgical staffing was adequate and there were sufficient numbers of doctors in the service to respond in a timely way to the needs of patients. We were told it was sometimes difficult to recruit to some posts and that the allocation of junior doctors from the deanery was sometimes an issue; however, we were told the division utilised advanced nurse practitioners (ANPs) and associate physicians (AP) to supplement junior doctors and there were plans to recruit and develop these roles further.

Consultant ward rounds were undertaken daily with ward rounds being undertaken at weekends for new patients and those for whom a review was requested. Doctors we spoke with stated their workloads were manageable. Junior doctors stated there was always access to advice and support from senior surgical staff and consultants and they could access that support at all times.
Doctors told us that the training programme was good, there were plenty of opportunities for development and learning.

Vacancy rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a vacancy rate of 10.7% for medical staff in surgery at The Countess of Chester Hospital. The trust reported no vacancy target.

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

Turnover rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a turnover rate of 22.3% for medical staff in surgery at The Countess of Chester Hospital; this was higher than the trust target of 10%. The trust has specifically stated that trainee grades are not included in this figure.

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

Sickness rates

The Countess of Chester Hospital

From July 2017 to June 2018, the trust reported a sickness rate of 1.8% for medical staff in surgery at The Countess of Chester Hospital; this was lower than the trust target of 3.65%.

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

Bank and locum staff usage

The Countess of Chester Hospital

We have been unable to calculate bank and agency usage as a proportion of the total number of shifts available because the total shifts available provided by the trust does not include permanent staff.

The table below shows the numbers of hours in surgery at The Countess of Chester Hospital from July 2017 to June 2018 that were covered by medical bank and locum staff or left unfilled.

In total, 11,870 hours were filled by bank staff and 16,513 hours were covered by agency staff to cover sickness, absence or vacancy for medical staff.

In the same period, 264 hours were unable to be filled by either bank or locum staff.

<table>
<thead>
<tr>
<th>Ward / unit name</th>
<th>Number of bank hours</th>
<th>Number of locum hours</th>
<th>Number of unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>This Trust</td>
<td>England average</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>931</td>
<td>3,675</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>726</td>
<td>3,805</td>
<td></td>
</tr>
<tr>
<td>Vascular</td>
<td>2,921</td>
<td>1,427</td>
<td></td>
</tr>
<tr>
<td>General surgery</td>
<td>1,741</td>
<td>2,103</td>
<td></td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>2,587</td>
<td>417</td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>1,135</td>
<td>1,958</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>410</td>
<td>2,192</td>
<td></td>
</tr>
<tr>
<td>Plastics</td>
<td>830</td>
<td>936</td>
<td></td>
</tr>
<tr>
<td>Oral and maxillofacial surgery</td>
<td>561</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Upper GI</td>
<td>20</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Colorectal</td>
<td>12</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Surgery total</strong></td>
<td><strong>11,870</strong></td>
<td><strong>16,513</strong></td>
<td></td>
</tr>
</tbody>
</table>

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

**Staffing skill mix**

In June 2018, the proportion of consultant staff reported to be working at the trust was slightly higher than the England average and the proportion of junior (foundation year 1-2) staff was the same.

**Staffing skill mix for the whole time equivalent staff working at Countess of Chester Hospital NHS Foundation Trust**

(Source: NHS Digital Workforce Statistics)

**Theatres Staffing**

The service had enough theatres staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
During our inspection we found that there were sufficient staff in theatres to protect patients from avoidable harm. Operating theatres were staffed in line with Association for Perioperative Practice (AFPP) minimum standards. This was achieved with the significant use of bank and agency staff. Operating theatres staff reported that staffing was often a challenge. Managers stated they would always staff in line with Association for Perioperative Practice standards or the operation would be cancelled. Agency theatre staff were block booked for extended periods where possible to offer continuity and familiar staff. Theatres managers were looking at ways to attract and retain staff and were working on improving the culture and investment in staff to reduce staff turnover and improve morale. However, the service had a significant issue with a shortage of scrub nurses and used high levels of bank and agency staff. Furthermore 21% of shifts that remained unfilled.

**Records**

Staff kept records of patients’ care and treatment and these were up-to-date; however, we saw a lack of documented care plans. Records were not stored in a way which prevented unauthorised access.

Patient records were a mix of paper and electronic records. During our inspection we found that initial risk assessments being recorded electronically, however when risk was assessed as medium or high we did not see corresponding care plans nor measures implemented to reduce that risk. For example, we saw documentation which recorded patients had been identified as being at risk of falls, but we did not see any falls reduction care plans nor documentation of potential measures that may have reduced the likelihood of falls. We only saw care plans implemented when a patient had already fallen. This was confirmed by staff who said that despite being at risk measures such as enhanced staff presence would not be implemented unless the patient had already fallen.

There were three places where patient records may have been recorded, the electronic record, the ‘nursing’ end of bed folder and the medical records folder. We saw that information was recorded appropriately. We found that patient records were stored in trolleys which were not lockable, this meant that the security of these documents could not be guaranteed as records may be accessed by unauthorised individuals. We also saw some issues with the standard of record keeping. Some records contained illegible hand writing in the notes. Some staff did not print their names and state their designation i.e. Doctor, Nurse etc. and some records had loose leaves which could be lost.

The hospital participated in an initiative called the ‘Cheshire Care Record’. This was an electronic record shared between hospitals, GPs, community health, mental health and social care practitioners. This was intended to prevent patients having to repeatedly provide the same information to care providers and ensure key information such as medications, allergies and test results is shared.

**Medicines**

The service followed best practice when prescribing and recording medicines. Patients received the right medication at the right dose at the right time. However, the recording of temperatures where medicines were stored was not robust.

During our inspection we found medicines, including controlled drugs were stored safely and in line with best practice guidance and trust policy. We did find however that some intravenous fluids were not stored appropriately. We saw that due to issues with storage some had been stored on
the wards in a way that did not prevent unauthorised access or prevent the possibility of tampering by unauthorised persons.

In theatres we saw that medicines had been prepared in advance for the morning list of patients. This was not in line with best practice.

We reviewed records that demonstrated that staff carried out daily checks on controlled drugs and stocks to ensure medicines were reconciled correctly. During the inspection we also checked a sample of controlled drugs on each ward and department and found the stock balances correlated with the registers. We also saw that the controlled drugs book showed evidence that two staff members had signed for controlled drugs. We saw correct recording of ‘wasting’ of controlled drugs, where the full contents of a vial were not prescribed.

We were told that on occasions when there was only one registered nurse on duty at night that a support worked would act as second checker for controlled drugs. Whilst this is permissible, guidance states this should be checked by staff who had been assessed as competent to do so. There was no such competency checking process in place on the surgical wards.

We found that medicines requiring cool storage were kept in medicines refrigerators. However, we found the recording of temperatures of those refrigerators was not being undertaken in a way which established if the refrigerator had been out of appropriate temperature range and so it was not known if the medicines remained safe to use. Furthermore, there was no recording of ambient room temperatures, therefore no assurance that medicines had not been exposed to extreme temperatures above 25ºC, which may have affected their effectiveness.

11 prescriptions charts were checked during our inspections and were generally satisfactory, however, we found the following issues; three charts did not have allergy status recorded and checked appropriately. Four patients did not have their weight recorded and five records did not have end dates for antibiotics 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.

The division used an electronic incident reporting and management system. Reports were submitted by completing sections of an electronic form. The person reporting had the option to be notified of the outcome of their incident. Staff stated they understood the system, it was easy to use and they would report incidents.

Staff we spoke with were familiar with the types of incidents that should be reported, such as patient safety incidents, staffing issues and equipment failures. We saw evidence that incidents and associated risks in the surgery division were escalated through a series of committees and governance structures to senior managers and so that information regarding patient safety was shared.

The serious incident panel met weekly; there was representation from the director of nursing and quality, the associate medical director for quality, the associate director for risk and safety, patient experience team members and safety team members. Any immediate learning identified and critical information was shared on a safety banner on the website and emails were circulated. This was followed by in-depth investigations and root cause analyses. This were shared with staff in
bulletins and fortnightly newsletters. The service had a theme of the month and also topic of the week, these were highlighted on posters, emails, newsletters and screen savers on the computers and these were shared at surgery team safety brief at ward and area level.

Staff we spoke with did not demonstrate awareness with the duty of candour processes, however when this was explained they agreed they would be open and honest with patients. Managers in the division did demonstrate awareness and provided examples when this was applied in practice. 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 reviewed a sample of investigations relating to serious incidents, we found each was investigated appropriately. Each report contained evidence of actions taken to prevent future incidents and there was identification of lessons to be shared, together with an action plan. There was evidence that 72-hour rapid reviews had taken place to identify any immediate issues.

**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 October 2017 to September 2018, the trust reported no incidents which were classified as never events for surgery.

*(Source: Strategic Executive Information System (STEIS))*

Since the trust supplied this data there had been a never event in the surgical division in October 2018. This was a wrong site anaesthetic block, that is the anaesthetic block was delivered to the wrong limb. A root cause analysis investigation was underway and some initial learning and reflection had taken place.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 20 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from October 2017 to September 2018. A breakdown of the incident types reported is in the table below.

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>6</td>
<td>30.0%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>5</td>
<td>25.0%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>4</td>
<td>20.0%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>2</td>
<td>10.0%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

*(Source: Strategic Executive Information System (STEIS))
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 three new pressure ulcers, three falls with harm and two new urinary tract infections in patients with a catheter from August 2017 to August 2018 for surgery.

(Source: NHS Digital)

During the inspection we observed that safety thermometer information was being displayed in a prominent place on the wards we visited. The information was updated regularly to keep patients and visitors informed about the ward performance.

Is the service effective?

Evidence-based care and treatment

Although the service was aware and followed some evidence based care pathways, they did not always follow national guidance around certain care plans such as falls.

National Institute for Health and Care Excellence (NICE), evidence based practice guidance, alerts and updates were reviewed for changes at trust level by the ‘Associate Director of Risk and Safety’. This was cascaded to the specialty audit leads to ascertain how these impacted on their scope of practice. The Trust’s governance board and clinical improvement and assurance committee also reviewed compliance. Any departure from guidance was debated, risk assessed and added to the risk register. The service used an information technology system to monitor and manage the implementation of new guidance.

Care pathways and care bundles such as fractured neck of femur, revascularisation surgery, abdominal surgery such as colectomy and stoma surgery reflected National Institute for Health and Care Excellence guidance and were followed by surgical teams. These were in keeping with latest evidence based guidance.

The service did not implement robust care plans in relation to some identified risks such as falls risks.

The division used technology and equipment to enhance the delivery of effective care and treatment, such as the use of the tele tracking system to monitor the patients’ location and journey through the service. This is reported to have improved access and flow through the hospital and reduce unwanted delays for patients.
The division followed best practice in relation to the pre-operative assessment processes; this ensured patient risk was identified and minimised as much as possible. It also aimed to optimise patients for surgery to provide the best possible outcomes.

In line with best practice, ward staff were supported to care for patients with presenting mental health conditions through the provision of psychiatric liaison staff employed by the local NHS mental health trust. The psychiatric liaison service worked 24 hours a day, 7 days a week with patients of all ages who required mental health input.

The service carried out a range of local clinical and nursing care audits to assess compliance against evidence based care and treatment, such as the fracture neck off femur pathway, Colorectal venous thromboembolism prophylaxis and percutaneous endoscopic gastrostomy insertion. Such audits were cascaded through clinical quality groups and actions had been put in place to improve standards as required.

**Nutrition and hydration**

The service made adjustments for patients’ religious, cultural and other preferences.

Staff gave patients enough food and drink to meet their needs and improve their health, however the service did not highlight patients’ individual needs well and there was a lack of assurance that these needs were being met. The service did not always follow latest guidance on fasting before an operation and sometimes patients unnecessarily went for longer periods than necessary without fluids.

The patient’s records we checked included appropriate assessments for nutritional intake to highlight those at risk of malnutrition. We observed that those deemed at risk were highlighted on their records and that risk assessments were reviewed at appropriate intervals. We found patients on food charts and fluid balance charts had these completed and updated appropriately. And during our inspection we saw staff helping patients with their food and drinks during meal times.

However, there was no red tray or similar system in place to highlight those patients who needed assistance or encouragement with eating and drinking. There were also no notes on boards behind beds to advise domestic staff on nutritional needs. Furthermore, the care and comfort staff who played a significant role in assisting patients at meal times and did not attend handovers nor have access to the electronic system. This posed a risk that patients' nutritional needs or need for assistance may be missed. Staff told us this did not happen as ‘we know our patients’, however there was no formal system in place to provide assurance of this.

Surgical wards had access to dietitians and speech and language therapists during core hours who could provide advice and support for those needing dietetic assistance or those with swallowing difficulties. The wards also had access to a diabetes specialist nurse who was available for advice for patients and staff. We saw evidence that blood glucose monitoring was undertaken at regular intervals and that those patients whose readings were out of range were escalated appropriately.

Patients were instructed to fast for six hours before their admission times. Sometimes patients would not go for their surgery until several hours later, therefore sometimes patients unnecessarily went for longer periods than necessary without fluids. This was not in keeping with latest guidance from the Association of Anaesthetists of Great Britain & Ireland.

Patients we spoke with were satisfied with the quality and choice of food and that was provided, they stated there was a good choice and food was of a good quality. Patient led assessments of
the care environment found that food scores were 93% for ward food, this is better than the England average score of 87% for 2018. There were menu options which met patients’ religious and cultural preferences.

**Pain relief**

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

Surgical wards and theatres recovery areas assessed pain as part of the early warning score system; the measurement of pain levels was recorded alongside clinical observations on the patients’ chart. Patients reported good attention and responses by staff to their pain levels. However, we found there was a risk of delays to administration of controlled drugs when there was only one registered nurse on duty at night. Some staff said they had to wait for a nurse from another area to check their drugs before they could administer them to the patient.

Staff also had access to a dedicated pain team with specialist pain control nurses within core working hours. Out of hours and at weekends, pain advice could be sought from the on-call anaesthetist. We saw evidence that the pain team was utilised and that where pain relief was difficult to achieve a pain team review was requested.

**Patient outcomes**

**Relative risk of readmission**

**The Countess of Chester Hospital**

From May 2017 to April 2018, all patients at The Countess of Chester Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Urology and general surgery patients at The Countess of Chester Hospital had lower than expected risks of readmission for elective admissions when compared to the England averages.

- Vascular surgery patients at The Countess of Chester Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions - The Countess of Chester Hospital**

![Elective Admissions Chart](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.*
From May 2017 to April 2018, all patients at The Countess of Chester Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery and trauma and orthopaedics patients at The Countess of Chester Hospital had lower than expected risks of readmission for non-elective admissions when compared to the England averages.

- Vascular surgery patients at The Countess of Chester Hospital had a higher than expected risk of readmission for non-elective admissions compared to the England average.

Non-elective admissions - The Countess of Chester 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 site based on count of activity

(Source: Hospital Episode Statistics)

Readmission rates for all admissions except for vascular admissions was lower (better) than the England average, with fewer readmissions than expected. The service was looking at vascular service performance measures to identify ways to improve.

National Hip Fracture Database

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 7.2% which was within the expected range. The 2016 figure was 6.4%.

The proportion of patients having surgery on the day of or day after admission was 85.1%, which met the national standard of 85%. This was within the top 25% of trusts. The 2016 figure was 76.0%.

The perioperative medical assessment rate was 99.1% which failed to meet the national standard of 100%. This was within the top 25% of trusts. The 2016 figure was 94.8%.

The proportion of patients not developing pressure ulcers was 97.9%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 97.8%.

The length of stay was 27.9 days, which falls within the bottom 25% of trusts. The 2016 figure was 28.2 days.

(Source: National Hip Fracture Database 2017)

National Bowel Cancer Audit
In the 2017 National Bowel Cancer Audit, 66.4% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate. The 2016 figure was 49.5%.

The risk-adjusted 90-day post-operative mortality rate was 0.0% which was within the expected range. The 2016 figure was 0.7%.

The risk-adjusted 2-year post-operative mortality rate was 20.6% which was within the expected range. The 2016 figure was 12.7%.

The risk-adjusted 30-day unplanned readmission rate was 8.4% which was within the expected range. The 2016 figure was 7.5%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 57.0% which was within the expected range. The 2016 figure was 53.5%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.2% for Abdominal Aortic Aneurysms; this was within the expected range. The 2016 figure was 1.0%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 33 days, worse than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 2.4%; this was within the expected range. The 2016 figure was 4.7%.

(Source: National Vascular Registry)

National Oesophago-Gastric Cancer National Audit

In the 2017 National Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 12.6%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2016 figure was 12.9%.

The trust was not eligible for the risk adjusted 90-day post-operative mortality rate metric.

The proportion of patients treated with curative intent in the Strategic Clinical Network in 2017 was 43.9%. This was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2017)

National Emergency Laparotomy Audit

The National Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80%
and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), the Countess of Chester Hospital NHS Foundation Trust achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 113 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 70 cases.

The site 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 59 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 41 cases.

The risk-adjusted 30-day mortality for the site was within the expected range, based on 113 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.

In 2016/17 performance on groin hernias was similar to the England average in terms of the EQ Vas score and scored better than the England average in the EQ-SD index.
For varicose veins, performance was mixed compared to the England average, with slightly worse scores in the Varicose Vein Questionnaire and better scores for the EQ VAS index. For the EQ-SD Index the trust performed worse than England in terms of the number of patients who improved but did not provide any data on the percentage of patients who worsened.

For hip replacements, performance was about the same as the England averages.

For knee replacements performance was mixed across the three indices. Performance was slightly worse than the England average for the EQ VAS index, about the same as the England average for the EQ-5D index and slightly better than the England average for the Oxford knee score.

(Source: NHS Digital)

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Managers in the surgical division undertook care matrix audits once per months where they look at 10 patient records and check certain elements of care provision. Any issues found were raised with staff and improvements made. Themes are analysed and shared as topics of the month as appropriate. The service undertook various local and clinical audits to assess the effectiveness of their care delivery. The service used national clinical audits to benchmark themselves against other services to identify areas for improvement. The service was generally comparable with England averages for most indicators.

**Competent staff**

**Appraisal rates**

**The Countess of Chester Hospital**

From April to June 2018, 88.2% of staff in surgery at The Countess of Chester Hospital received an appraisal compared to the trust target of 95%. A breakdown by staff group is provided below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic and technical staff</td>
<td>32</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>27</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>76</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>146</td>
</tr>
<tr>
<td>Qualified nursing and health visiting staff</td>
<td>147</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>15</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>2</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>458</strong></td>
</tr>
</tbody>
</table>

The trust’s appraisal target was met by three of the eight staff groups within the surgery core service shown above, however it should be noted that the data only covers a three month period.
Qualified nursing and health visiting staff achieved an appraisal completion rate of 83.5% and medical staff achieved an appraisal rate of 95.0%.

(Source: Routine Provider Information Request – Appraisals tab)

The service made sure staff were competent for their roles. However, managers did not always have time to appraise staff’s work performance and hold regular supervision meetings due to competing pressures for their time.

Managers in the surgical division had identified ways to improve compliance with annual appraisal compliance and an action plan was in place. Nurse managers said that at lot of their time for management tasks had been taken up with undertaking clinical work and ‘being in the numbers’. That is having responsibility for patient care due to their being insufficient staff on duty. They said this meant they got behind on appraisals and could not hold regular supervision meetings, this is reflected in the data supplied by the trust which showed the division had failed to meet the trust target for appraisal completion for nurses. Those managers expressed concern as the completion of appraisals was linked to pay for nurses.

Nursing staff told us they felt there were opportunities for professional development within the division such as additional training course and learning new skills. There was a practice education facilitator in place for nursing staff within the surgical division.

The junior doctors we spoke with during our inspection and those who participated in focus groups told us they felt supported by senior colleagues and that they had access to the advice and guidance they required from senior surgeons and consultants. Junior doctors said the surgery division provided good opportunities for learning and development.

**Multidisciplinary working**

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

The surgical division encompassed a range of disciplines who worked closely together to meet patients’ needs. Regular multidisciplinary team meetings were held on the wards and at senior levels to discuss patient care. Staff we spoke with stated they felt valued and supported as part of a team and were very much involved in the planning and delivering of care and treatment.

During our inspection we spoke with a range of staff from different specialisms and grades who told us that the multidisciplinary team relationship was good and the team worked well together. There were a range of therapy staff present on the ward such as occupational therapists, physiotherapists, dieticians and speech and language therapists.

During our inspection we saw therapists working with patients to facilitate patients’ rehabilitation following surgery, assessing patients’ needs, assisting and teaching them to use equipment aids and mobilise. We saw the colorectal team were heavily involved with patients on the colorectal ward. There was access to a wide range of specialist staff such as stoma care, palliative care, tissue viability specialists, which could be requested for advice and input. Ward pharmacists were involved in the planning and care of patients and were integral to the ward team. They provided facilitated medicines reconciliations for inpatients and organised medicines patients were to take home with them.

**Seven-day services**
Urgent diagnostic procedures and laboratory tests were available at the weekends. Processes were in place so ensure that urgent requests were undertaken and reported on in a timely way.

Physiotherapy services were present on the wards at weekends and provided assessments and consultations. Specialist services such as dietitians, occupational therapy, access to specialist nurses, was not available at weekends.

Ward rounds were undertaken at weekends, some of these were consultant led, and others were undertaken by the registrars. Consultants were available in person on site or by telephone during evenings and weekends.

Pharmacists were available on a daily basis during core hours and operated an out of hours on call service outside of these hours.

The service had an emergency theatre for urgent and emergency procedures which was available and staffed 24 hours a day, seven days a week. There was also a second on call team rota. This reflected The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2007): Emergency Admissions: A journey in the right direction? And Royal College of Surgeons (RCS) (2011): Emergency Surgery, Standards for unscheduled surgical care guidance.

Health promotion

The surgical division had access to smoking cessation, alcohol advice and other health promotion advice. A referral could be made for patients who agreed to help to give up smoking or alcohol reduction.

The pre-operative assessment nurse provided health promotion advice as required to enable patients to be in the best health for their surgery. This included advice around venous thromboembolism and medicines advice and about the specifics of their planned surgery.

Staff in the division were encouraged to have a flu vaccination to help reduce the spread of flu between staff and patients. The trust staff take up for the flu vaccine was 79.9% for the year 1 September 2017 to 28 February 2018. They also encouraged the take up of flu vaccine for patients and the local population.

A range of leaflets were available on health promotion such as weight loss, healthy eating and smoking cessation and condition specific advice. Other information such as advice on staying healthy during winter and colds and flu advice was also provided on the trust webpage and via social media sources.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The Countess of Chester Hospital

The trust set a target of 95% for completion of Mental Capacity Act (MCA) training. The trust informed us that this course encompasses deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA training from July 2017 to June 2018 for nursing staff in surgery at The Countess of Chester Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The trust reported that from July 2017 to June 2018, Mental Capacity Act (MCA) training was successfully completed by 86.2% of nursing staff in surgery eligible for the training.

A breakdown of compliance for MCA training from July 2017 to June 2018 for medical staff in surgery at The Countess of Chester Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>July 2017 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>112</td>
</tr>
</tbody>
</table>

The trust reported that from July 2017 to June 2018, Mental Capacity Act (MCA) training was successfully completed by 92.6% of medical staff in surgery eligible for the training.

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They documented decisions about capacity and best interests and followed trust policy and procedures when a patient could not give consent.

The trust had a consent policy in place which had been reviewed and updated regularly and was in keeping with current guidance. This was accessible to staff electronically.

A Mental Capacity Act and Deprivation of Liberty Safeguards policy was in place, up to date and accessible to staff. This was in keeping with best practice guidance. Staff received training in this area as part of the mandatory training programme. A deprivation of liberty means taking someone’s freedom away. A 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 their movement and 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. The service provided evidence that mental capacity assessments had been undertaken according to policy.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

During our inspection we observed interactions between staff and patients, we found that staff demonstrated kindness, patience and a caring approach to their patients and their families. We overhead positive exchanges between staff and patients and this showed that staff were courteous, empathetic and respectful to those in their care. We saw that staff protected the privacy and dignity of patients by ensuring cubicle curtains were pulled around the bedsides and that single room doors were closed whilst patient care was taking place. We also saw that staff introduced themselves and sought permission before entering areas and before initiating care.
The patients and relatives we spoke with were very happy about the care given by staff and they found staff kind and helpful. They stated they were treated with dignity and respect. One patient told us, “I was very impressed with the theatres and recovery staff, nothing was too much trouble, I felt in good hands”. Another patient said, “staff always find the time to speak with me, even though they are busy, I cannot fault the care they give”.

Staff had shown their compassion for their patients by arranging a wedding for a surgical ward long term inpatient. After the patient had proposed on the ward staff facilitated a wedding two weeks later, they arranged catering, decorations and even took the patient’s dog to the dog groomers and arranged for it to be present for the ceremony together with the patients’ friends and family.

**Friends and Family test performance**

The Friends and Family Test response rate for surgery at Countess of Chester Hospital was 33% which was better than the England average of 27% from August 2017 to July 2018.

A breakdown of friends and family test performance for surgical wards with a minimum of 100 responses from August 2017 to July 2018 is below. All but one surgical ward (Ward 44) scored above 90% for percentage recommended for the year overall.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp 1,2</th>
<th>Resp. Rate</th>
<th>Percentage recommended 3</th>
<th>Annual perf 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 40</td>
<td>731</td>
<td>51%</td>
<td>Aug-17: 89%</td>
<td>Sep-17: 100%</td>
</tr>
<tr>
<td>Ward 45</td>
<td>524</td>
<td>48%</td>
<td>Aug-17: 88%</td>
<td>Sep-17: 100%</td>
</tr>
<tr>
<td>Ward 55</td>
<td>439</td>
<td>25%</td>
<td>Aug-17: 88%</td>
<td>Sep-17: 94%</td>
</tr>
<tr>
<td>Ward UROL</td>
<td>237</td>
<td>23%</td>
<td>Aug-17: 89%</td>
<td>Sep-17: 100%</td>
</tr>
<tr>
<td>Ward PLAS</td>
<td>190</td>
<td>30%</td>
<td>Aug-17: 95%</td>
<td>Sep-17: 100%</td>
</tr>
<tr>
<td>Ward 53</td>
<td>159</td>
<td>40%</td>
<td>Aug-17: 100%</td>
<td>Sep-17: 95%</td>
</tr>
<tr>
<td>Ward 52</td>
<td>150</td>
<td>28%</td>
<td>Aug-17: 93%</td>
<td>Sep-17: 92%</td>
</tr>
</tbody>
</table>

**Key**

| Highest score to lowest score | 100% | 50% | 0% |

1 The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).
2 Sorted by total response.
3 The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Note: sorted by total response

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

During our inspection, we saw that staff were aware of and supported the emotional needs of patients. Staff demonstrated a supportive and reassuring approach to patients who were admitted for surgery and those who were anxious and nervous. We saw that staff established a good rapport and put patients at ease. They explained the processes and procedures and what would happen next so as to try to help patients feel less anxious.
There was emotional support from specialist nurses such as cancer nurses and stoma nurses for patients who had been given difficult news such as a cancer diagnosis and for those who were having life changing surgery. The stoma specialist nurses offered some emotional support but formal counselling could also be facilitated upon discharge in the community. Patients were also referred to community support groups and charitable organisations where staff thought this would be beneficial.

Pre-operative nurses assessed if additional help was required for extremely anxious or nervous patients, those with phobias or those living with mental health issues. They could arrange for reasonable adjustments to be made, that would make attending or staying in the hospital a little easier. They could also gain support from specialist nurses such as the learning disabilities specialist nurse.

The chaplaincy service was available for spiritual, religious or pastoral support to those of all faiths and beliefs. There was a multi faith chapel in the hospital and they offered confidential support to patients and relatives. There was also a bereavement service and bereavement staff offer support and advice for those who had lost a loved one at the hospital.

**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. During our inspection we observed that patients were included and consulted in decisions about their care and treatment. We found staff to be approachable, supportive and respectful of patients’ wishes. We saw that staff gave patients the opportunity for discussion and sufficient time to have their questions answered and that staff explained procedures and next steps clearly in a way that patients understood and could relate to.

The patients and relatives we spoke with told us they received clear and comprehensive information verbally and in letters and leaflets provided to them and this information enabled them to make informed choices. Patients said they felt involved in their care and treatment and that members of staff actively encouraged participation in discussions. They told us they felt their opinions and views mattered to staff. They said they were given time to express their wishes and felt they were listened to.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people. However, the surgical triage unit was not always functional.

The service used patient and community representatives to provide input into service planning and design. They also worked with local healthcare partners and the local clinical commissioning groups to determine service provision, often working in partnership to achieve this. The division provided vascular services on behalf of two other local NHS organisations to improve sustainability of the service.

The facilities and premises within the surgical division were suitable for the services that were being delivered. For instance, the jubilee day surgery unit had been designed with consideration of
the best practice guidance for such units, such as; a patient collection and drop off point close to the entrance and ready access to operating theatres.

GP admissions were referred into the service with the intention that they were diverted away from the accident and emergency department. They therefore attended the surgical triage unit however, this unit was not always fully functional. It did not have a permanent base at the time of the inspection and the area it was allocated was often used as an escalation area and used for beds for inpatients. This meant that patients had to go to the accident and emergency department which created additional demand in that department. Staff in the surgical triage unit then had to attend the accident and emergency department to assess patients but did not have examination rooms or the facilities needed to effectively function as a surgical assessment unit. Furthermore, this was creating more admissions for patient who need not necessarily require inpatient admission, but who could have diagnostic tests or preparation and whom could return for their procedure as a planned admission. We were told that local GPs had expressed their concerns that the patients they referred were forced back through the accident and emergency route which negated the benefit of a GP referral and created a bottleneck in the service. We were advised that the surgical division were aware of these issues and were creating a business plan to establish a permanent location for the surgical triage unit where it could properly function as such and divert patients away from the accident and emergency department and thus improve the patient flow into the surgical wards and theatres.

Average length of stay

The Countess of Chester Hospital - elective patients

From June 2017 to May 2018 the average length of stay for all elective patients at The Countess of Chester Hospital was 3.8 days, which is slightly lower compared to the England average of 3.9 days.

- The average length of stay for trauma and orthopaedics elective patients at The Countess of Chester Hospital was 3.6 days, which is lower compared to the England average of 3.8 days.

- The average length of stay for vascular surgery elective patients at The Countess of Chester Hospital was 7.3 days, which is higher compared to the England average of 5.1 days.

- The average length of stay for urology elective patients at The Countess of Chester Hospital was 2.4 days, which is slightly lower compared to the England average of 2.5 days.

Elective Average Length of Stay - The Countess of Chester Hospital

![Chart showing average length of stay for different specialties at The Countess of Chester Hospital and England average.]

*Note: Top three specialties for specific site based on count of activity.*
The Countess of Chester Hospital - non-elective patients

The average length of stay for all non-elective patients at The Countess of Chester Hospital was 5.6 days, which is higher compared to the England average of 4.9 days.

- The average length of stay for general surgery non-elective patients at The Countess of Chester Hospital was 4.0 days, which is slightly higher compared to the England average of 3.8 days.

- The average length of stay for trauma and orthopaedics non-elective patients at The Countess of Chester Hospital was 10.8 days, which is higher compared to the England average of 8.7 days.

- The average length of stay for vascular surgery non-elective patients at The Countess of Chester Hospital was 12.7 days, which is higher compared to the England average of 10.8 days.

Non-Elective Average Length of Stay - The Countess of Chester Hospital

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

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

The service took account of patients’ individual needs. However, they did not always highlight individual needs effectively.

The surgical division screened patients for dementia and cognitive impairment on admission, however if the screening identified an issue, the service did not have a way of highlighting this to others. They did not use the white board behind the patient’s bed, nor a symbol to alert others to the patient’s needs. They did highlight this at handover but not all staff with responsibility for direct patient care were present at this handover.

There was a vulnerable person lead nurse; this individual had a large portfolio of responsibility for patient living with dementia, learning disabilities, cognitive impairments, mental health issues and safeguarding needs. There was also a dementia specialist nurse in post who provided awareness raising sessions to staff and the public. The service participated in the ‘dementia friends’ initiative and this had achieved a milestone of 6,000 staff and members of the public signing up as a
dementia friend. These individuals could be consulted in order to support staff caring for patients with individual needs.

Most areas were suitable for patients using wheelchairs. There were wheelchair accessible toilets available around the hospital and in wards.

There were processes in place for people who needed translation and interpretation services, interpreters were available in person and by telephone. We saw that advice leaflets and information leaflets stated that they were available in other languages, the advice was written in various common scripts and languages to enable individuals to understand how to obtain copies they could access. There were no stock copies of leaflets in any of the more common language spoken by members of the local community, but they were available on request.

A Spiritual Care Centre at the Countess was open 24 hours a day, seven days a week and provided a space for patients, relatives and staff of all faiths and no faith. There were facilities to cater for various faith groups such as washing facilities and prayer mats and services such as prayer or meditation sessions were held. There was also a quiet room which was available for use. The chaplaincy team undertook regular ward visits to the surgical wards and offered services to patients. Spiritual documents were available in a range of formats. The catering team also provided meals that met spiritual needs including Halal, Kosher and veganism for both staff and patients.

The Trust had a transgender group to enable greater participation and understanding of the needs of this group. The trust had a carer’s policy, which ensured if a patient had a carer, then they would be contacted and advised of the patient’s admission.

The service had an Equality Human Rights Steering Group and a Faith and Culture steering group to help raise issues, queries and discuss service improvement for marginalised and hard to reach groups.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Access to the surgical division services were through different routes. Some patients requiring urgent care came through the accident and emergency department, some less urgent referrals came from GPs via a telephone triage service which was a partnership with other local hospitals. Non-urgent consultations took place in outpatient clinics and referred for surgery as required.

The service had access to a complex discharge team who could facilitate access to community and social care packages for patients with ongoing needs to help them to return home or a place of care safely. The tele tracking system could indicate the number of planned discharges taking place that day to facilitate the management of beds across the trust. Take home medicines were ordered in advance so were ready when patients were fit for discharge and in some cases, were prescribed as part of the pre-assessment process to prevent delays on the day of surgery.

The tele-tracking system had improved patient flow to free up beds more quickly. Each patient wore a patient tracker which was activated upon moving around the hospital and activating one of the 4,000 sensors around the hospital. The co-ordination centre could where the patient was located and when they moved between areas such as from the operating theatre into the recovery area or when they were sent for diagnostic tests. They could also see when a bed became available following discharge. This enabled a turnaround team to quickly attend to clean the bed
space to enable another patient to be admitted, this had reduced turnaround times from four to under two and half hours. We were also told this had improved theatres utilisation and adherence to operating lists schedule times. The tele-tracking screens were available in the wards and departments across the hospital.

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

From August 2017 to July 2018 the trust's referral to treatment time (RTT) for admitted pathways for surgery was better than the England average.

![Chart showing referral to treatment (percentage within 18 weeks) for 2017-2018.](chart)

(Source: NHS England)

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

From August 2017 to July 2018, five specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>91.8%</td>
<td>81.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>89.3%</td>
<td>76.7%</td>
</tr>
<tr>
<td>ENT</td>
<td>79.7%</td>
<td>63.2%</td>
</tr>
<tr>
<td>General surgery</td>
<td>75.9%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>72.7%</td>
<td>60.1%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>66.8%</td>
<td>68.5%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>53.8%</td>
<td>59.8%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The division had a referral to treatment improvement programme in place. They had assessed the issues affecting performance and were implementing strategies to improve efficiency and better use of operating theatres time. They were also putting on additional sessions where possible to combat any identified delays and increasing the use of day surgery sessions to increase throughput where it was safe to do so.

**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 cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years, the percentage of cancelled operations where the patient was not treated within 28 days at the trust was consistently higher than the England average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Countess of Chester Hospital NHS Foundation Trust**

![Graph showing percentage of cancelled operations over time]

Over the two years, the percentage of cancelled operations at the trust was consistently higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

*(Source: NHS England)*

The division experienced high numbers of cancelled operations and operating theatres managers had examined the reasons for this and how improvements and efficiencies could be achieved. They considered cancelled operations but also looked at other inefficiencies such as delays in commencing theatres lists and overruns. They also looked at how they could optimise the effectiveness of scheduling. They had introduced various initiatives such as ‘the golden patient’ whereby certain patients were identified as being those that could smoothly progress through the theatres process in order to prevent bottle necks and delays. They had produced a patient
postcard to ensure that pre-operative advice was embedded and operations were not cancelled due to pre-operative preparation not being fully followed by the patient which might delay or cause the operation to be cancelled. They had also produced charts and data and displayed this in a way that staff could visualise the causes of inefficiencies. These initiatives had started to show improvements and there was optimism that these would continue to improve. It was believed these would in turn improve theatres utilisation and referral to treatment times.

Learning from complaints and concerns

Number of compliments made to the trust

The Countess of Chester Hospital

From 26 July 2017 to 25 July 2018 there were 86 complaints about surgery.

The trust took an average of 39.5 days to investigate and close complaints. This met the trust target of closing complaints within 40 days

The table below shows the complaints broken down by subject:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>46</td>
<td>53.5%</td>
</tr>
<tr>
<td>Appointments</td>
<td>16</td>
<td>18.6%</td>
</tr>
<tr>
<td>Communications</td>
<td>9</td>
<td>10.5%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>6</td>
<td>7.0%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>5</td>
<td>5.8%</td>
</tr>
<tr>
<td>Staff values and behaviours</td>
<td>3</td>
<td>3.5%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>86</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

The Countess of Chester Hospital

From 26 July 2017 to 25 July 2018 there were 33 compliments about the surgery core service at the hospital.

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

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The trust had a complaints policy in place which was accessible to staff and reflected latest best practice recommendations. The staff we spoke with understood the process for dealing with complaints and could advise patients and relatives on how to raise a concern or make a complaint. During our inspection we observed posters and leaflets displayed in patient and public areas which provided information on how to make a complaint. How to complain was also described on the trust internet and social media sites.

Complaints were managed by a trust wide complaints team called the customer experience team, who followed the policy regarding acknowledgement of complaints and complaint response times.
The team had executive team input from the chief executive and director of nursing and quality. The hospital also had a patient advice and liaison team (PALS), who assisted members of the public, patients and relatives to raise concerns. Investigations were undertaken with input from matrons, ward managers and relevant staff in order to gather information on the concerns raised. We reviewed a sample of complaint responses and found that these appeared to be thorough and candid and apologies were given as appropriate. Letters advised complainants about the Parliamentary and Health Service Ombudsman if they felt their complaint was not resolved to their satisfaction.

We saw evidence that complaints were shared with staff and learning opportunities were considered. We saw that there had been changes made following learning from complaints. For example, we saw additional training was given to the planned care and waiting list teams to improve an error identified which caused a delay in treatment.

We saw that information about complaints was discussed at team meetings, divisional quality and safety teams and the monthly patient experience operation group. Trends and recurring themes were examined and that learning was implemented and shared. Recurring themes formed part of the ‘topic of the month’ and were discussed and shared in publications. Topics discussed so far have been insulin management, vital signs, pathology labelling and sampling, falls prevention and duty of candour. Patient stories were also highlighted and some patients attended to present their stories to staff to highlight their experiences.

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. Managers of the surgery and anaesthesia division appeared skilled and knowledgeable and capable of leading the division effectively. The senior management team were passionate about their service and very enthusiastic to drive forward changes and improvements. They were keen to enhance the experience of working in the service for staff and to better utilise resources for the benefit of the local population.

On reviewing quality strategy and model hospital improvement documents and from speaking to managers on inspection, it appeared that leaders were sighted on the challenges facing the surgery division. Theatres managers had embarked on various initiatives to improve culture and efficiency in the operating theatres, whilst this was a work in progress, there was evidence of some improvement. However, the pace of change was and progress on meeting challenges was sometimes and issue.

Ward managers told us they sometimes found it difficult to balance their managerial tasks as were undertaking clinical work and were ‘in the numbers’ two to three times per week. They felt this prevented them effectively undertaking their managerial commitments and had to work late and work through breaks. They said this impacted on appraisal rates and that this could result in implications for staff as appraisals were now linked to pay increments.

Staff on wards and in theatres told us the visibility of senior managers was minimal, they stated executives did not often undertake walk rounds in clinical areas.

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 trust values were “Safe, kind and effective” and their vision was; “Delivering NHS care locally that makes our staff and our community proud”. The trust aimed to deliver ‘Integrated Care at its Best’ and wanted to deliver the best possible care to our patients, in the most appropriate location. They described their plan as being “… about our patients. It is about delivering the best clinical outcomes, exceeding expectations of our patients in terms of the experience they receive, using all of our resources at our disposal well and supporting our staff to deliver this by being a valued employer”.

The trust’s strategic direction was built on three key programmes of work; ‘West Cheshire Way’, this was about working with local healthcare and other related partners to drive service re-design and integrate care for the residents of Western Cheshire. ‘Integrated Specialist Services’, this was about providing the right services to meet the needs of patients, either as part of clinical network or as a specialist centre in their own right. And ‘Countess 20:20’ this was about reviewing their core services to ensure they delivered the health outcomes and quality that patients deserved.

The surgical division had its own role in this strategy and was in the process of examining service provision to determine sustainability and deliberating internally and with others about partnerships and where services would best be placed. The division was working on strategies to increase efficiency and performance in the division and seeking to enhance the appeal of the division as an employer of choice, by improving communication and morale amongst staff and bettering the working environment to encourage staff to remain in the service.

Culture

Managers across the trust were intent on working towards achieving a positive culture that supported and valued staff, however staff morale across a number of staff groups was low.

Morale was low amongst many staff groups, various members of staff from different staff groups echoed similar sentiments. They felt that the service had been running on good will for some time and they felt that good will was running low. They expressed they were worried about making a mistake due to the pressure they were under and felt they were compromising themselves and patients due to being stretched too far. Some staff felt that a lack of investment in the trust had resulted in staff leaving the organisation to work elsewhere, with better conditions and opportunities. However, other staff felt loyal to the trust and hoped in time they would see improvements. Some described that although there were pressures in the wider organisation and division, staff were very fond of their smaller area based teams who they described as being like a family and being very supportive. There was some optimism that new executives will make changes and staff were hopeful of new investment and initiatives.

The theatres managers had identified issues with morale and the culture in theatres and had believed this had led to a high staff turnover and some safety and performance issues. They had introduced some initiatives to understand and address some of those issues such as a staff survey, the ‘perfect week’ and revised theatres checklists. These had started to bring about improvements and managers were planning to repeat the survey and continue to build on improvements. Staff in theatres said they had seen some improvements and felt better that changes were happening.

Governance
The service had a systematic approach to continually improve the quality of its services, although this had not always been effective in driving improvements in quality and performance.

There was evidence of clinical governance procedures and quality measurement processes. These ensured issues were identified and escalated through a series of committees and steering groups to trust and executive level.

The surgery division had divisional governance and quality and safety meetings, such as the Planned Care Governance Board, which fed into the Quality, Safety & Patient Experience Committee (QSPEC). Groups discussed issues relevant to the surgical division such as the divisional risk register, complaints, clinical audits, clinical effectiveness, serious incidents, patient experience and morbidity and mortality. Where necessary these would be shared with other divisions and the trust senior executive teams.

There was evidence that there was sharing of information with and from committees and groups down to staff on the ground. There were ward level and divisional meetings such as the safety brief processes which shared performance, quality and safety information with staff, there was evidence of the sharing of information in a timely way. Minutes from these meetings were recorded and shared. The service initiatives and quality strategy cited clear outcomes against which they would measure their success.

Management of risk, issues and performance

The service did not always demonstrate effective systems for identifying risks, nor did it always implement effective measures to eliminate or reduce them.

The surgery division did not always recognise, nor implement strategies to reduce the safety risks within the department. The performance around safety measures was not kept in check and so managers were not aware of the potential for things to go wrong. For example, checks on performance in the 5 steps to safer surgery and the World Health Organization checklist had been audited but issues had not been recognised and as such not improved. Managers were aware of issues in sepsis identification and management and also around falls, yet they were slow to respond and did not implement measures to mitigate these risks in a timely way.

The surgery division had a ‘risk register’ which highlighted areas of risk to the running of the service. This register comprised of individual and some generic risks such as staffing, potential failure to deliver performance and risks associated with the environment and equipment. Some surgical division risks were also captured on the trust wide risk register. Each item on the register was allocated to an individual with designated responsibility of the risk, included the date it was entered onto the register and the date for review.

The service participated in various initiatives to monitor performance and potential risks such as ‘Learning from deaths’, ‘Mortality Surveillance Group’, the Learning Disabilities Mortality Review (LeDeR) Programme. Matrons audited nursing care through spot checks to identify any potential issues or risks. Issues found were highlighted through team meetings and team bulletins.

Managers in theatres had implemented some positive work around recognition of barriers to performance and engaged with staff to encourage them to become part of the solution, this was work in progress. The operating theatres efficiency programme had taken steps to measure and understand the issues and barriers within the department and had devised programmes to improve performance, such as the cancelled ops improvement programme to analyse and eradicate some of the causes of cancellations. Theatres utilisation programme to understand and
combat late starts and finishes and introduce more efficient scheduling. Some of these measures had started to bring about positive results. Progress and performance was measured through the ‘Planned Care Governance Board’ which reported to the ‘Quality, Safety & Patient Experience Committee’ (QSPEC).

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust and division collected, analysed, managed and used information well to support its activities. The trust had invested in an electronic information technology system which was able to track patients through their journey to assist with flow through the department. It was also capable of mapping patient staff interaction and much more. Additional functionality was being rolled out over time.

Electronic systems were armed with secure systems access and security safeguards. There was satisfactory access to terminals and mobile computers to enable staff to access the systems.

Staff had access to the trust intranet which provided a range of internal and external resource materials to assist staff in their day-to-day tasks. Staff also used the system to access training and development information and courses. The used the electronic system to request diagnostics, specialist nurse and speciality referrals such as tissue viability and dieticians.

Ward and department managers had access to various information sources such as staffing and human resources information, equipment and stock information and audit results and performance dashboards to enable them to manage the day-to-day running of their services and offer areas for improvement. The trust intranet had electronic policies, standard operating procedures and policies available to staff electronically.

**Engagement**

The trust engaged well with patients, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. However, staff engagement was less effective and the visibility of leaders was poor.

The service had a ‘Public engagement and involvement strategy’ in place. This determined how the service interacted with the public to determine how feedback and interaction was achieved.

We saw that the hospital had engagement with five ‘equality groups’. These were the Equality and Human Rights group, Disability Equality Group (DEG) Age and Safeguarding, Gender and Sexuality, and Faith and Religion. These groups consisted of key staff, stakeholder, charities and patient representatives, who discussed matters directly relating to patient care of individuals with one or more protected characteristics. They shared their experiences of the service as patients, advocates and carers and provided insight through their ‘patient stories', they also acted as mystery shoppers and completed audits of translation services and hearing loop facilities and tested staff knowledge around the needs of vulnerable people.

The service was a key participant in the ‘Integrated care partnerships’, they were active partners in the region and engaged with plans for establishing new and sustainable partnerships in the local healthcare economy.
The hospital engaged in community events such as the Chester Cathedral lecture around ‘death and dying’ in which staff from the hospital undertook presentations. They also promoted ‘Refugee week’, celebrated ‘Chinese New Year’ by decorating the canteen and serving Chinese food and engaged in a the ‘National day of remembrance for victims of forced marriage and honour crime’.

The service participated in the Friends and Family test programme, where questionnaires were completed by patients to determine if they would recommend services to their friends and family. During our inspection we saw that there were boxes present on wards however there were no cards available for patients to complete. We also saw that response rates were very low.

Barometer groups are in place to gain feedback from staff and stakeholders to gauge opinion and feedback, there has been consultation on topics ranging from performance management and operational challenges. The trust engaged with staff over creating new organisational values through an initiative called ‘values are designed by you and lived by us all’.

‘What’s Brewing?’ was a drop-in session in the restaurant for staff to speak with executives and discuss issues they wanted to raise. The GEM awards recognised staff who had gone the extra mile and accomplished achievements, several staff from the surgical division had their contributions recognised and celebrated and appeared in magazine and the trust website.

However, trust-wide strategies to engage with staff were not successful. Staff in the division stated the visibility of leaders was poor and they felt disconnected with the larger organisation and divisional leaders. They felt disempowered and not listened to.

**Learning, continuous improvement and innovation**

The trust had some effective programmes in place to improve services. However, they did not always demonstrate a systematic approach to improving the quality of its services. There were safety and performance issues which were not recognised and others that were known by not addressed effectively.

The service did not always demonstrate that they were making progress and improvements against known safety and performance issues at a satisfactory pace. Although some promising improvement programmes were in place, they were not always focussed priority issues such as safety in particular issues such as sepsis, staffing and risk culture.

The service had undertaken initiatives around the ‘model hospital’ programme, they were striving to reduce process and clinical variation and promote collaboration, integration and performance. The service had a wide variety of projects in progress to streamline processes and increase efficiencies whilst improving or maintaining high standards of care. The service had shared this vision with representatives from other healthcare organisations in the country and put on a showcase to demonstrate their work on the model hospital initiative.

A Quality Improvement Strategy was in place and there had been staff open days and training course to teach staff about quality improvement. A network of quality champions had been established to take forward improvements in operational processes, care delivery and service development. Ward managers undertook a ‘care matrix audit’, they examined 10 cases per months and looked at aspects of care and if they could be improved.

The trust had introduced a new Co-ordination Centre Programme, this was a patient flow technology which had been installed in the hospital. It used a patient tracker wristband and 4,000 sensors installed throughout the hospital to give a real-time picture of a patients flow through the service. This was reported to be particularly useful in the operating theatres as it tracked a patient from the anaesthetic room into the operating theatres and into recovery, this was said to reduce
delays and bottlenecks and improve efficiency in the department. The trackers were also used to locate equipment and staff and were linked to patient records. The system was used by porters to facilitate transfers to different parts of the hospital and by the ‘turn around team’ who were alerted when a patient was discharged so they could clean the bed space in a timely way for the next patient. The trust report that that turn-around times had reduced from 4 hours to 2.5 hours since the system had been implemented. They stated that this gave 156 hours of nursing time back to the hospital per week. The system also had greater functionality which included the possibility to map staff contact time with patients and show where staff were and how much time they spent on particular duties.

The vascular department had trialled and implemented a virtual wound management service where community nurses could access specialists in the surgical service to provide advice and guidance on wound management including surgical wounds through IPADs and electronic devices. This initiative had been successful in enabling patients to remain in the community whilst receiving the best treatment and has prevented re-admissions.

The urology department had implemented the use of a minimally invasive ‘lift’ procedure to treat patients with benign prostatic hyperplasia who experienced lower urinary tract symptoms. This was undertaken as a day case, offered improved clinical outcomes and reduced length of stay as an alternative to a prostatic urethral lift to surgical procedure.