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

Wirral University Teaching Hospital NHS Foundation Trust serves a population of about 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West area.

A list of the acute hospitals/ community locations is below.

<table>
<thead>
<tr>
<th>Name of site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrowe Park Hospital</td>
<td>Arrowe Park Road, Upton, Birkenhead, Wirral CH49 5PE</td>
<td>Delivering a full range of emergency and acute services for adults and children, plus maternity services</td>
</tr>
<tr>
<td>Clatterbridge Hospital</td>
<td>Clatterbridge Road, Bebington, Wirral, CH63 4JY</td>
<td>Undertaking the majority of planned surgical services and some specialist rehabilitation</td>
</tr>
<tr>
<td>St Catherine’s Community Hospital</td>
<td>Church Road, Tranmere, Wirral, CH42 OLQ</td>
<td>Provides x-ray and some outpatient services</td>
</tr>
<tr>
<td>Victoria Central Health Centre</td>
<td>Mill Lane, Wallasey, Wirral, CH44 5UF</td>
<td>Provides x-ray and some outpatient services</td>
</tr>
</tbody>
</table>

(Source: Trust Website / Routine Provider Information Request (RPIR) – Sites tab / Acute Provider Information Request (RPIR) – Context acute tab)
Arrowe Park Hospital is one of two hospital sites managed by Wirral University Teaching Hospitals NHS Foundation Trust. The hospital is the main site and provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people’s services, maternity and gynaecology services and a range of outpatient and diagnostic imaging services.

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

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

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

Wirral University Teaching Hospital NHS Foundation Trust was last inspected in May 2018. We assessed the well-led aspect of the trust as inadequate at the last inspection.
Is this organisation well-led?

Leadership

Board Members

Of the executive board members at the trust, 0% were Black and Minority Ethnic (BME) and 71% were female.

Of the non-executive board members 0% were BME and 28% 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%</td>
<td>71%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0%</td>
<td>28%</td>
</tr>
<tr>
<td>All board members</td>
<td>0%</td>
<td>54%</td>
</tr>
</tbody>
</table>

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

Since our last inspection the trust leadership team had stabilised, however at the time of the inspection there was an interim chief nurse in place due to the post recently becoming vacant. The interim chief nurse also held a post as director of quality and governance. At this inspection there was also a substantive chairman in post and a new medical director. The trust had also now appointed a new company secretary.

There was a broad mix of skill and experience across the board, with financial, clinical and operational experience across the non-executive directors. The chair was a well-established chair and had a strong network with key stakeholders across the geographical patch.

The leadership team were beginning to come together to implement key improvements and standards in care and had the abilities to provide high quality effective services.

The divisions had also completed the changes in people in leadership roles since the last inspection. Some of these teams were more embedded than others. Divisional leads were required to undertake a 360-degree feedback as part of their appraisal. The feedback was collated and key areas for the individual staff member to consider were identified. A 360-degree feedback is a process through which feedback from an employee’s colleagues is gathered. As part of the appraisals for medical leaders they also undertook a 360-degree feedback in conjunction with the North West Leadership Academy. Clinical directors of divisions now attended trust board meetings to help improve communication and oversight from board to clinical services.

There was a planned board development programme in place. This included workshops on developing an effective and compassionate unitary board and building a culture of continuous improvement. This was provided by an external facilitator. However, some of these workshops had been deferred as other priorities for the board to discuss and implement had become apparent. For example, the quality strategy. We were told that the workshops were due to recommence in the new year. In February 2019 a board development programme session was provided by the advancing quality alliance.

At the last inspection there was no formal leadership strategy in place, but the trust had plans for a leadership programme. At this inspection, there was a leadership development framework for staff at every level. This was for aspiring leaders and for front line leaders and managers to executive directors. There were plans to deliver a BME leadership programme in the trust in the next 12
months. In the last financial year 712 member of staff out of 3424 eligible staff had participated in an internal leadership development programme. The trust had worked with the NHS North West Leadership Academy to develop relevant leaders to complete a shadow board programme which had commenced in October 2019.

For 2019 the trust had developed a staff education and development directory. This included details of courses available to staff. For example, a range of vocational qualification, which included leadership, deaf awareness courses and sign language to preceptorship and clinical supervision workshops. There was also a clear section around mandatory and role specific training required to help ensure there was a safe workforce to help reduce the risk of harm to staff, patients and visitors.

At the last inspection we found that the programme of visits to clinical and non-clinical areas by executives and non-executive directors had ceased. Before the inspection the trust provided information on executive visits up to March 2019. However, this did not include many visits to service areas but was mainly a weekly executive lunch in the restaurant for staff to attend if they were available. Staff in services also told us that visibility of executives was variable. Senior staff told us that visits to wards and service areas were agreed and undertaken on the day a board meeting took place but was not a formal programme.

There was a non-executive and a governor who worked in partnership with the clinical and corporate divisions.

There were also a number of professional coaches within the organisation to support staff who were managers and leaders throughout the trust. Coaching is a form of development by which an experienced person, called a coach, supports another member of staff to achieve a specific personal or professional goal.

Pharmacy was established within services and the multidisciplinary focus to medicines optimisation had improved. The director of pharmacy and medicines management was the trust’s accountable officer reporting to the medical director, working as a member of the trust board of directors and providing leadership for trust-wide projects. The director of pharmacy was established as the system lead for the Cheshire and Merseyside healthcare partnership.

The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. This was an improvement from the last inspection when the trust was not meeting this regulation.

The trust had a fit and proper person’s policy and procedure for all non-executive and executive directors. This had been approved in May 2018. The procedure detailed the requirements in accordance with the regulation. There was now an annual process completed to monitor compliance with the fit and proper person’s requirements. The policy also stated that the person responsible for the procedure was the trust secretary who reported compliance or non-compliance to the chairman.

We reviewed 13 personnel files for executive directors, non-executive directors and board directors and found the majority to be consistent in compliance with the regulation and trust policy. However, there were ten which did not have a disqualified director check in 2018 but had had one at the beginning of 2019 and again in March 2019 when the majority of annual checks were completed. Staff told us that this was due to an internal audit commissioned by the trust to identify any gaps in assurances. The trust policy stated that these checks should be completed on an annual basis on 31st March.
However, the non-executive directors we spoke with were unaware of the new Kark recommendations that had recently been issued in February 2019. These included developing competencies for directors and expanding the definition of serious misconduct.

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

Vision and strategy

The trust had in place a set of values which had been reviewed and changed since the last inspection and these were visible throughout the trust. These had been developed following feedback of over 2,500 staff, patients and visitors to the trust. The vision was ‘together we will deliver the best quality and safest care to the communities we serve’. The values underpinning this vision were caring for everyone, committed to improvement, respect for all and embracing teamwork.

The trust was committed to improve safety and had set an objective to achieve a bronze award in 2019/20 moving to a gold ward by 2021/22 as part of the Royal Society for the Prevention of Accidents health and safety awards. The trust was in the process of identifying the relevant evidence which would be submitted by January 2020.

The trust had a five-year organisational/operational strategy in place titled ‘locally focussed-regionally significant’ which would end in 2021. Work had begun on developing a new strategy and strategic ambitions had been drafted. There was a themed workplan in place to support the implementation of this strategy. This identified key actions against each objective and staff were identified to take forward these actions. Progress was monitored. However, senior staff we spoke with told us that this strategy was no longer in line with the direction of the trust and at the time of the inspection there was no refresh of the strategy in place.

There was an organisational development plan for 2018 to 2021 which focussed on seven key themes: leadership, values and behaviours, engagement, valuing the workforce, learning organisation, healthy workforce and inclusivity. This was developed in discussion with services, staff and trade union partners. The nursing, midwifery and allied health professions workforce strategy was agreed in 2018 and key actions had been included in the organisational development plan.

The trust reported that the first year of the new quality strategy for 2019 to 2022 was predominately around establishing the framework for implementing, baselines and training for quality improvement pioneers. The quality strategy included ensuring there was a positive patient experience, care is progressively safer, care is clinically effective and highly reliable and that the trust stood out. There was a key outcome in the strategy to ensure every patient was reviewed by a senior doctor at least once a day. However, during the inspection we found that this was not being completed. In medical services we found a number of patients who were outliers on other speciality ward who had not had a medical review every day. We noted that at the patient safety and quality board meeting in September 2019 it was recorded that there was no team identified to work on this key outcome. This was one of the risk areas noted by the trust.

A recent ‘6 facet survey’ had been completed by the estates team which provided information on which to base decisions about the future of the estate. There was also a draft estates strategy, and this was going to be linked with the clinical strategy.
There was now a patient experience and engagement strategy 2019 to 2022 in place. This included key milestones to help monitor implementation of the strategy. The strategy included, ensuring a positive patient partnerships experience through a shift in leadership and organisational culture and to use patient feedback to drive quality improvement and learning. There were plans to monitor this through key committee meetings.

The trust was beginning to develop good-better-best strategies, and this could be seen in the patient experience and engagement strategy. This approach consisted of different version of the outcome where each version improves on the previous throughout the life cycle of the strategy.

There were a number of infection, prevention and control policies in place to help control the risk of infection for patients. These strategies included grouping of patients and continued daily review of all MRSA colonised patients.

At the last inspection we found that there was no workforce strategy in place. At this inspection we found that the trust had recently carried out a self-assessment and the results showed the need to develop a workforce planning model and a credible workforce strategy. The trust was seeking to introduce the workforce repository and planning tool and a pilot was underway in of the clinical divisions. The trust told us that the next step would be to develop a trust wide workforce plan. There was a people strategy for 2019 to 2022. This was in place to help shape and build the workforce. There were building blocks identified for success, for example, engagement, clear performance standards and creating a safe environment for all.

The pharmacy service had successfully embedded extended roles and there were further plans to develop roles to support divisions, for example, pharmacist NMP’s as part of the pain team and pharmacy perioperative team. The pharmacy team had recently created service delivery links with the local workforce action board. There was a current recruitment plan to build the team in support of these extended services. The team achieved a seven-day working service using a combination of extended roles and overtime.

Since the last inspection, the trust had begun to stabilise the leadership, systems and processes and had plans in place to move the strategic direction of the trust. There was trust representation on workshops within the health Wirral programme and some were led by senior leaders in the trust. For example, unplanned care.

**Culture**

The trust had a policy in place relating to the duty of candour requirements. This outlined the process that verbal notification and an apology, that a moderate or above suspected patient safety incident has occurred, must be made to the patient or their family/carer within 10 working days of the incident being reported followed by a summary letter. However, the policy also stated that agreement had been made with the local commissioning group that the 10 working days would begin once the root cause analysis investigation process had been confirmed. This meant there was a risk that the trust would not be compliant with policy as not all moderate or above incidents may result in a root cause analysis investigation or a delay due to the processes to agree that a more in-depth investigation was to be undertaken. This was the same at the last inspection.
We saw on the serious incident log that an incident reported on 15 September 2019 was not declared as a serious incident until 4 October 2019 and then the duty of candour process was implemented with a letter due to be sent on 18 October 2019.

On reviewing the system to record incidents and duty of candour we found that there were occasions when the evidence to support the implementation of duty of candour was not available. We reviewed 15 records on the electronic system and found that on two occasions we could find no evidence that the duty of candour letter had been sent. Staff we spoke with told us and we observed, that the letters were attached to the incident record on the electronic system.

Following the review of the system we reviewed information provided by the trust which showed there had been a total of 44 moderate severity or above incidents between 1 September 2019 and 30 September 2019. This recorded that duty of candour had been applied for 27 of these incidents. For the other incidents a reason why, this had not been applied had been recorded. For example, a staff incident or a pressure ulcer on admission. We noted that the incidents were being graded according to the risk of the incident happening again rather than the level of harm to the patients. This meant there was a risk and it was unclear if duty of candour was being applied to the correct level of incidents.

The duty of candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers.

Freedom to speak up guardians work with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safely. The role of the freedom to speak up guardians had been created as a result of recommendations from Sir Robert Francis in February 2015. The trust had one in place. There were freedom to speak up champions in services and the trust were recruiting for a wider network of champions. There was also a dedicated phone line available for staff to use 24 hours a day seven days a week. Freedom to speak up guardians are entirely independent and work with the executive team to protect patient safety and the quality of care and to improve the experience of all staff. We saw that there were leaflets around the trust with information for staff and contact details. There was an executive lead and non-executive lead for freedom to speak up. However, the non-executive directors we spoke with were unaware of the new guidance that had been in place since July 2019. This was the guidance for boards on freedom to speak up in NHS trust and NHS foundation trusts. Part of this guidance included named executive and non-executive leads as well as a freedom to speak up strategy. The trust told us that there was not a specific strategy in place but freedom to speak up was included in the people strategy. We saw that there were actions included on the work programme for this strategy around freedom to speak up systems.

The trust was delivering a programme of training for staff of freedom to speak up. Since January 2019 all staff have been expected to attend the training. We saw evidence that some staff had completed this training. Since April 2019 to end of September 2019 the total number of staff who had spoken up was 41, whereas the whole of the previous year there was a total of 46. The trust has asked a neighbouring NHS trust to review its practices into freedom to speak up processes to identify if further improvements need to be made.

We were told by staff we spoke with there were examples where issues had been raised with the freedom to speak up guardian and champions, but these had not responded in a timely way by managers in the trust.
There was a number of contacts from staff before and during the inspection informing us that they had concerns regarding the culture at the trust. Some staff told us they did not feel valued and some reported that nothing had changed since the last inspection. Whilst staff satisfaction across the trust had improved in some areas since the last inspection, in others staff satisfaction was mixed. We were told of examples where communication from managers in the trust had included instructions in capital letters and in red ink which they found ‘dictatorial’.

Information provided by the trust before the inspection showed the following:

### WUTH NHS Staff Surveys 2014 -2018

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worst % of staff saying they experienced at least one incident of bullying, harassment or abuse from managers in last 12 months.</td>
<td>27.3%</td>
<td>22.6%</td>
<td>23.8%</td>
<td>24.1%</td>
</tr>
<tr>
<td>WUTH</td>
<td>10.7%</td>
<td>14.2%</td>
<td>12.5%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Average % of staff saying they experienced at least one incident of bullying, harassment or abuse from colleagues in last 12 months.</td>
<td>13.6%</td>
<td>12.9%</td>
<td>13.2%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Best</td>
<td>6.5%</td>
<td>6.8%</td>
<td>7.3%</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

Between May 2018 and April 2019 there had been 31 grievances citing bullying and harassment as an issue. These were investigated, and actions taken which included disciplinary or being informally resolved through mediation.

Some senior nursing staff we spoke with told us that the culture in the trust was changing and there was a drive on improving culture and changing behaviours. They told us that there was now more support available and executive directors were aware of the areas where the culture needed to improve. They also told us that there was less silo working and a focus on quality improvement. For example, the enhanced recovery pathway for surgery and the enhanced maternity care team.

The senior leadership team for medical staff told us that there was more active medical engagement since the last inspection and gave examples of how this had been achieved, but also recognised there was still work to be done to improve further. A further medical engagement
survey was completed in October 2019 and this showed improvement compare to the one undertaken before our last inspection in 2017. The three largest percentage improvements were having purpose and direction, participation in decision making and change and climate for positive learning.

Following an external review of culture in the trust in December 2016 actions against the recommendations had been put in place. However, from the information received before the inspection, these had not all been fully implemented. The trust had provided a position statement as at July 2019 and what next steps were required. This included undertaking a cultural review in radiology and to develop a further action plan to address bullying in the workplace. Also, the trust was planning to implement the ‘just and learning culture’ early in 2020. This is an approach to ensure the organisation culture was fairer and safer. Further concerns that had been raised by staff were now being identified.

The pharmacy business plan was embedded into the pharmacy appraisal system and was instilled into the staff objective ensuring the team were working to a common goal. Pharmacy staff we spoke to felt valued and supported which enabled them to make a difference.

Site specific whole pharmacy team meetings continued to take place each week ensuring good communication. The pharmacy team had recently implemented a video call to enable the satellite hospital pharmacy team to participate in training sessions.

There had been a number of initiatives undertaken by the executives since the last inspection to help change the culture. These included removal of designated car parking spaces for the chief executive, door to the executive offices being open at all times, in touch with the board sessions and changes to the maternity policy following an experience of a member of staff after the premature birth of their child. During the summer holiday period the trust had facilitated a food bank service to support members of staff who were in need during the school holidays.

The trust provided the following breakdowns of medical and dental, qualified nursing and midwifery, and qualified health professional staff by ethnic group as a percentage of the trust’s entire workforce.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Qualified nursing and midwifery staff (%)</th>
<th>Qualified allied health professionals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>4.3%</td>
<td>24.6%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Asian</td>
<td>1.7%</td>
<td>1.6%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Black</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>0.2%</td>
<td>0.4%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Unknown / Not stated</td>
<td>0.2%</td>
<td>0.4%</td>
<td>5.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6.9%</strong></td>
<td><strong>27.3%</strong></td>
<td><strong>5.4%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity tab)
NHS Staff Survey 2018 results – Summary scores

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

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

- Health & wellbeing
- Safe environment - Bullying & harassment

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

(Source: NHS Staff Survey 2018)
Workforce race equality standard

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

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

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

Notes relating to the scores:
- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all orientated the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts’ circumstances.

<table>
<thead>
<tr>
<th>WRES Indicators from ESR (HR data)</th>
<th>BME Staff</th>
<th>White Staff</th>
<th>Are there statistically significant difference between BME and White staff?</th>
<th>Last year and this year? (BME staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Proportion of clinical staff in senior roles, band 8+</td>
<td>4.6%</td>
<td>4.5%</td>
<td>✓</td>
<td>1.3%</td>
</tr>
<tr>
<td>1.2 Proportion of non-clinical staff in senior roles, band 8+</td>
<td>7.7%</td>
<td>4.8%</td>
<td>✓</td>
<td>9.7%</td>
</tr>
<tr>
<td>2 Proportion of staff who are shortlisted for appointments</td>
<td>7.6%</td>
<td>14.2%</td>
<td>✓</td>
<td>-7.6%</td>
</tr>
<tr>
<td>3 Proportion of staff entering formal disciplinary processes</td>
<td>1.2%</td>
<td>1.9%</td>
<td>✓</td>
<td>0.5%</td>
</tr>
<tr>
<td>4 Proportion of staff accessing non-mandatory training and CPD</td>
<td>47.4%</td>
<td>46.6%</td>
<td>Not assessed</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WRES Indicators from the NHS Staff Survey</th>
<th>Proportion of respondents answering “Yes”</th>
<th>Are there significant differences between…</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME staff</td>
<td>White staff</td>
<td>All staff</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>5 Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>Trust 32.0%</td>
<td>25.2%</td>
</tr>
<tr>
<td>Peer group 26.9%</td>
<td>27.9%</td>
<td>28.7%</td>
</tr>
<tr>
<td>6 Staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>Trust 36.0%</td>
<td>29.6%</td>
</tr>
<tr>
<td>Peer group 30.1%</td>
<td>26.0%</td>
<td>27.0%</td>
</tr>
<tr>
<td>7 Staff believing that the trust provides equal opportunities for career progression or promotion</td>
<td>Trust 70.2%</td>
<td>84.7%</td>
</tr>
<tr>
<td>Peer group 69.8%</td>
<td>86.3%</td>
<td>83.3%</td>
</tr>
<tr>
<td>8 Staff experiencing discrimination at work from a manager / team leader or other colleague?</td>
<td>Trust 13.9%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Peer group 15.9%</td>
<td>6.7%</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust staffing numbers</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 [BME Voting Board Members] and Board compared to overall staff demographic</td>
<td>[0]</td>
<td>[0]</td>
</tr>
</tbody>
</table>
As of 2018, one of the ESR staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

2. In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (7.6% of BME staff compared to 14.2% of White staff). This has decreased by 76.7% compared to the previous year, 2017.

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), the following indicators showed a statistically significant difference in score between White and BME staff:

7. 70.2% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS staff survey) which was significantly lower when compared to 84.7% of White staff. The score had decreased by 4.8% when compared to the previous year, 2017.

8. 13.9% of BME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey which was significantly higher when compared to 6.0% of White staff. The score had increased by 3.9% when compared to the previous year, 2017.

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), the following indicators showed a statistically significant difference in score between this trust and its peer group:

6. Staff experiencing harassment, bullying or abuse from patients in the last 12 months (2018 NHS staff survey) which was significantly worse when compared to its peer group.

(Source: NHS Staff Survey 2018; NHS England)

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

The trust had a published document for Workforce Race Equality Standard progress report for June 2019 with an action plan in place. These included establishing links with local community groups and to identify pro-active ways to support staff and potential new recruits.

Since the last inspection the trust had put in place equality and diversity groups and networks within the trust, for example, an LGBT and staff network. There is also a diversity and inclusion strategy for 2018 to 2022 which outlined key priorities. There was an implementation plan underpinning this strategy with actions and deadlines for completion identified.

We reviewed recent information provided by the trust around diversity and inclusion and disciplinary and grievances which showed no trends towards ethnicity or gender.

The trust had delivered a conference around transgender which was attended by approximately 130 people. This included awareness sessions on the subject. The trust was accredited with the Navajo Merseyside Kite Mark for LGBT following assessment. This indicated that the organisation was in line with statutory requirements and promoted best practice in engaging with the LGBT community.

There was also a living library where staff living with a disability went to share experiences. There was also a focus on supporting staff with long term and terminal illnesses. There were monthly
support ‘cafés’. The trust was also signed up to the TUC dying to work charter. This was to help alleviate some of the stresses and set out an agreed way in which an employee should be treated and supported in the event of a terminal diagnosis. It was also about the trust recognising that a terminal illness was a protected characteristic.

**Friends and Family test**

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

From June 2017 to May 2019 the trust scored within expected range.

The trust response rate scored between 11.1% and 25.3% between June 2017 to May 2019.

**Wirral University Teaching Hospital NHS Foundation Trust – response rate June 2017 to May 2019**

(Source: Friends and Family Test)
Sickness absence rates

The trust’s sickness absence levels from May 2018 to April 2019 were higher than the England average.

(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 18 indicators.

<table>
<thead>
<tr>
<th>Survey area</th>
<th>RAG</th>
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<tbody>
<tr>
<td>Curriculum coverage</td>
<td>○</td>
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<tr>
<td>Educational governance</td>
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<td>Reporting systems</td>
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<td>Rota design</td>
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<td>Teamwork</td>
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<td>Overall satisfaction</td>
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<tr>
<td>Clinical supervision</td>
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<td>Clinical supervision out of hours</td>
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<td>Handover</td>
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<td>Induction</td>
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<td>Supportive environment</td>
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<td>Work load</td>
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<td>Educational supervision</td>
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<td>Feedback</td>
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<td>Local teaching</td>
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<tr>
<td>Regional teaching</td>
<td>○</td>
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<tr>
<td>Study leave</td>
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</table>

(Source: General Medical Council National Training Scheme Survey)

The trust had an annual staff awards programme to recognise and reward staff. For 2019 these were called together wards, which mirrored the values of the trust. These awards included the excellence in patient care team award and innovation and improvement team award.

**Governance**

Since the last inspection the trust had reviewed governance structure in place.
The trust structures included board committees, divisional committees and team meetings. For example, a safety management assurance committee and a patient safety and quality board. There were cycle of business plans in place for key committees. These included what items would be discussed at meeting and when. For example, when the performance dashboard would be discussed at the trust board and when the ward accreditation outcomes would be presented to the board. There were also terms of reference for each of the committee meetings. Terms of reference define the purpose and structures of a committee or meeting. There were plans to review the effectiveness of the new structure in 2020 and a survey to be undertaken against the aims and objectives in the term of reference. However, this had not been done in the past.

On reviewing recent board papers and committee papers they were of a relatively good standard and contained appropriate information. Actions from meetings identified a person responsible and a timeframe for completion. This was an improvement from the last inspection. Some of the meetings were relatively new and still being embedded. For example, the health and safety management committee had only met for the first time in August 2019.

The director of pharmacy and medicines management was a member of the divisional oversight and management group which reported to the trust management board, and the quality and safety committee which reported directly to the board. The trust had links to the Pan Mersey committee and the Cheshire and Merseyside healthcare partnership. Staff worked rotationally which supported the development of partnership working.

The trust had in place a medical device database and a planned preventative maintenance schedule for each device and area of the hospital. At present there was not a rolling replacement programme for every device, but a replacement programme had recently been undertaken for a number of aging equipment.

We reviewed the trust’s policies and procedures. At the time of the inspection we found that out of the 30 policies reviewed only one policy was overdue for review. This was the consent policy. This was an improvement from the last inspection when we found that 24% of policies we reviewed were past their review date. There was also a policy and procedures development and management policy in place. This outlined the procedures, consultation and ratification processes. It also included the trust wide policy template to guide staff. This was good practice.

Position on policies were reported to the patient safety and quality committee. This outlined those due to expire and action for members of the meeting to take. These included taking the information back to the relevant service areas so that the policies would be reviewed in a timely way.

**Management of risk, issues and performance**

The trust had reviewed risk management processes since the last inspection which were based on good practice.

The trust reported regularly to other external agencies around seven-day hospital services. There were four priority standards identified for the trust, standard two, five, six and eight. The trust was reporting compliance with standard five and six and partial compliance with standard eight.
However, they were not compliant with standard two. This standard was for all emergency admissions to be seen by a suitable consultant within 14 hours of the decision to admit. The overall compliance with this standard during the week was 61% between July 2019 and September 2019 and at the weekend this dropped to 47%.

Changes introduced in July 2018 has seen the trust compliance for CAS alerts improve. Between July 2018 to October 2019 the trust had reached full compliance for all but one alert.

There was a central safeguarding team who identified and co-ordinated the trust response to mental health capacity issues and deprivation of liberty safeguards. Integrated to this team was the learning disability service. There was an alert system in place to let the learning disability team know if there were any patients within the hospital with a learning disability on a daily basis. There was also a matron responsible for dementia who liaised with a local mental health NHS trust.

At the last inspection there was a pathway that had been developed that when a patient required a deprivation of liberty being put in place the central safeguarding team would make the application to the local authority. However, we noted that this delayed the application as the team did not operate 24 hours a day.

Since the last inspection the trust had put in place a system that once a mental capacity assessment had been completed on the electronic system a deprivation of liberty application form was completed and automatically sent to the local authority direct for an urgent application rather than going through the safeguarding team.

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

There was a safeguarding assurance group in place which met on a quarterly basis. This meeting included designated professionals from the trust and clinical commissioning group as well as representatives from the divisions.

The safeguarding team produced an annual safeguarding report that was presented to the relevant committee. This report included challenges and priorities as well as key objectives for 2019/20. These included completion of a safeguarding training strategy in line with new intercollegiate documents and safeguarding thresholds for children and adults. Since the last inspection the trust had reviewed the training requirements for safeguarding children mandatory training. There was now a e-learning and face to face training which was in line with best practice guidance.

At the last inspection, safeguarding adult and safeguarding children’s training was done in one day and there was no evidence of refresher training as stated in the intercollegiate document that level 3 training needs to include refresher training over the three-year period at a minimum of two hours per annum and a minimum of six hours for those requiring more specialised training. As this inspection we found refresher training was available for staff. The trust was aware of the changes to the intercollegiate document for adults and had recently completed a training review and identified the further training that was required. The trust had in place up to date and appropriate safeguarding policies for adults and children and there was a trust safeguarding executive lead. There was an up
to date mental capacity act 2005 policy. There was also a policy in place for VIP and celebrity visits to help ensure the safety of patients.

Since the last inspection staff were recording any parental concerns which were looked at to identify any themes. Staff could clearly articulate the themes.

There had been a number of safeguarding referrals made to help protect vulnerable patients. Between 1 June 2018 and 31 May 2019 there had been a total of 223 adult referrals sent to the local authority to investigate and 2214 children referrals made to the trust safeguarding team to either refer to local authority to investigate or share with the local authority. The trust had a lead for criminal exploitation who attended the multi-agency criminal exploitation meeting to share information with external partners in care.

The trust had undertaken an audit of compliance with best interest for patients who lacked capacity. This was an improving picture but was still below the trust target of 100%. Education and support was being provided for areas were gaps had been identified.

The trust had a number of volunteers in place who had all been checked via the disclosure barring service and attended induction and mandatory training. They supported staff in various areas, for example, end of life care, newspaper delivery and the reminiscence team. There were also patient experience volunteers who collected feedback from patients to help identify any themes and trends for the trust to consider.

There was a risk management policy in place that was in date and version controlled. This outlined the aims, accountabilities, responsibilities and organisation framework for the management of risk across the organisation. It identified the risk management escalation processes and guidance on scoring risks using a matrix system. This meant that the trust provided guidance to staff to ensure risks were being mitigated.

Senior leaders met with the divisions monthly to review risks on the divisions risk register. They also reviewed corporate risks including human resources and organisational development risks. This was at the risk management committee. We observed one of these meetings and found the discussions to be appropriate and there was challenge on the management of the risks by the committee members.

The trust management board received a summary report at each meeting on the risk discussed at the risk management committee and the board reviewed risk updates and escalations via the trust management board chair's report. However, when we reviewed the paper that went to the trust board meeting in November 2019 the chair’s report only stated that the report from the risk management committee had been received. There was no summary overview for the board to enable full oversight of risks within the trust.

There was a process in place for urgent escalation of risk that could impact on trust objectives. These were to be reviewed by the division senior managers and executive director and reported to the chief executive within 24 hours of becoming aware of the risk.

The trust had pharmacy risks sited on its register. This included the national shortage of medicines; the pharmacy team were reviewing resource and process as a control measure. The pharmacy team were well established within wards and departments and continued to support timely access to critical medication. Trust internal communication had improved, the medication safety bulletin was
shared via multi-disciplinary or ward level meetings focussing on medication matters called ‘Druggles’.

Medicines reconciliation levels were set at a target of 90%. The level had been up to 84% a recent dip to 71% had been noted due to a change in service delivery, as a result the delivery model was being reviewed. Antimicrobial stewardship was embedded, and the dashboard stated 99.5% of prescriptions across the trust in October 2019 had a stop or review date.

Senior leaders met with the divisions on a quarterly basis to review performance. This looked at risk and performance issues and agreed actions to improve performance. These performance reviews fed into the trust management board for oversight of performance across the trust. This had been reinstated since the last inspection.

However, we had concerns regarding the performance of children’s and young people’s division and we identified areas for improvement on this inspection which indicated there had been a lack of sustained improvement in performance for a number of years. This service’s ratings had not improved over the last few years.

### Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Financial Year (2017/18)</td>
<td>Last Financial Year (2018/19)</td>
</tr>
<tr>
<td>Income</td>
<td>£337.0m</td>
<td>£353.2m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£18.2m)</td>
<td>(£33.0m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>(£355.1m)</td>
<td>(£386.2m)</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£0.4m)</td>
<td>(£25.0m)</td>
</tr>
</tbody>
</table>

The deficit reported in 2018/19 was higher than the previous year. At the time of RPIR submission trust projections for 2019/20 indicated that the trust will break even.

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

The Board were sighted on the significant risk within the system for both the trust and commissioners and achieving the financial plan for 2019/20. There were significant unfunded cost pressures which needed to be addressed with appropriate board oversight.

In relation to budgetary accountability and management, there had been progress made under the leadership of the trust’s acting director of finance. Further improvements were planned with the start of a substantive appointment in the new year.

The trust was at an early stage of developing plans to achieve financially sustainability within the system. Further work was required on assessing the financial impact of the system strategy, as well as the development of implementation plans within an agreed timescale.

The trust had done some analysis on the reasons for the underlying deficit but has not utilised this detail in the development of a clinically and financially sustainable strategy. Most board members were well informed on the key drivers of the deficit.

The trust had changed the approach to cost improvement planning for 2019/20 to get greater engagement and support from the operational teams. There was evidence of the use of Model Hospital and benchmarking information in the development of savings schemes. Historic delivery
has been mixed, with reliance on non-recurrent savings. The board emphasised that they felt limited in the ability to drive further significant efficiency improvements in the future, and system transformational change would be required going forward.

There was a business partner model for finance which supported the clinical divisions. There were positive comments from senior managers about the contribution the finance team made to supporting the operational teams and wider trust agenda. However, it was recognised that further development of this model would enhance support further.

There was a quality impact assessment of all cost improvement schemes with oversight from the Medical Director and Chief Nurse.

**Trust corporate risk register**

The trust provided a document detailing their 16 highest profile risks. Each of these have a current risk score of 15 or higher.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score</th>
<th>Risk review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/03/2019</td>
<td>195</td>
<td>Risk to patients of acquiring a healthcare associated infection/ increased possibility of outbreak.</td>
<td>20</td>
<td>31/07/2019</td>
</tr>
<tr>
<td>23/10/2018</td>
<td>29</td>
<td>There is an increased number of hospital acquired infections leading to patient harm within the division including CDiff/ MRSA/ CPE/ VRE/ E-Coli due to the standard of cleanliness in ward areas and operational pressures. Standard of cleanliness, hand hygiene compliance, ward environment, operational pressures and lack of isolation.</td>
<td>20</td>
<td>31/08/2019</td>
</tr>
<tr>
<td>06/06/2019</td>
<td>319</td>
<td>Failure to deliver cost reduction and cost control plans required to support overall financial plan competing regulatory priorities or unexpected spend to address quality/ compliance issues.</td>
<td>20</td>
<td>20/07/2019</td>
</tr>
<tr>
<td>04/06/2019</td>
<td>105</td>
<td>A failure to achieve and maintain financial sustainability – There is a risk of the Surgical division not being financial sustainable in the longer term leading to poor patient care and limited access to services. The continuation of on the day cancellations continue due to bed pressures at 40 - 60 cancellations a month.</td>
<td>16</td>
<td>07/08/2019</td>
</tr>
<tr>
<td>No provided</td>
<td>175</td>
<td>Nursing staffing levels are inadequate due to high levels of vacancies and sickness is having potential detrimental impact on patient safety and staff / Patient satisfaction</td>
<td>16</td>
<td>16/07/2019</td>
</tr>
<tr>
<td>01/03/2019</td>
<td>244</td>
<td>Environmental Team Capacity: Ability to efficiently and effectively manage IC agenda from a staffing perspective due to the amount of variation and fluctuation within the IC agenda ask.</td>
<td>16</td>
<td>28/07/2019</td>
</tr>
<tr>
<td>01/04/2019</td>
<td>25</td>
<td>Data from the Infection Control team has found there has been an increase in Hospital Acquired infections on ward 30 over the past six months. The age of the ward and poorly maintained environment makes it difficult to give assurance</td>
<td>16</td>
<td>01/08/2019</td>
</tr>
</tbody>
</table>
Cervical Screening Cytology is no longer provided at WUTH and is now provided by Liverpool Clinical labs in the Royal Liverpool Hospital until mid-November 2019 (provisional date) when the service will then transfer to Manchester. Liverpool Labs does not have an interface that can send results direct to Cerner resulting in two issues:
1) Screening patients’ results are emailed over daily and weekly with minimal detail
2) Any ad-hoc smears carried out in outpatients are not tracked and results are being sent through the post but to no central point.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score</th>
<th>Risk review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>21/05/2019</td>
<td>301</td>
<td></td>
<td></td>
<td>16</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>02/10/2019</td>
</tr>
</tbody>
</table>
consultant has some annual leave planned during the summer.

| 09/07/2019 | 349 | This is a patient safety risk due to delay/missed diagnosis if there is no photographic evidence of scope findings for MDT discussions etc. | 15 | 08/08/2019 |

(Source: Trust Corporate Risk Register)

The trust had a risk register in place which identified risks across all service areas. The risk register identified the risk descriptor, the lead for the risk and the risk rating. It also outlined the current controls in place to help mitigate the risk. There were also actions identified to help mitigate the risk further. Each action had a person responsible and a timeframe. There was a date identified when the risk would be fully reviewed. We observed that the risk registers were discussed at the risk management committee.

At the time of the inspection the highest risk was the risk of patients of acquiring a healthcare associated infection. The trust had put in a number of actions to help mitigate this risk as much as possible. We identified at the last inspection that the financial challenges for the trust were not identified on the risk register. On this inspection we found that this was clearly documented with actions to further manage this risk.

On reviewing the risk register at the last inspection, we found that there were a number of actions which had been identified to help mitigate the risk but had been ongoing for a long time. When reviewing the risk register during this inspection we found that the majority of actions had been recently identified, however, there were some that had been ongoing for some time. For example, an action to help mitigate the risk around replacement of equipment in radiology had been ongoing since 2016 and exploring pharmacy technician role within critical care to support the pharmacist had been ongoing since 2017. We noted that there was improvement in how risks were being managed, but there was still further work that could be done around timely implementation of actions

Board Assurance Framework

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

1. PERFORMANCE: Consistently deliver financial sustainability and performance standards
2. PEOPLE: Supported empowered workforce
3. PATIENTS: Pursuing quality improvement
4. PARTNERSHIPS: Improve services through closer integration

(Source: Trust Board Assurance Framework – May 2019)

The board assurance framework is a high-level document that records the key risks that could impact on the trust achieving its strategic objectives. This included the likelihood and consequences together with the gaps in assurances. Actions had been identified for the gaps and to improve on the controls. At the time of our inspection, we found there were executive leads identified for each of the risks. The board assurance framework was linked to key performance indicators and identified threats and opportunities to achieving the trust’s high-level strategic objectives. Senior leaders were aware of the top risks on the board assurance framework. There were plans in place to look at the number of operational risks that were linked to the strategic risks on the board assurance framework.
The board assurance framework and associated risk scores went to the trust board meetings on a quarterly basis and to the risk management committee every two months. On reviewing the board meeting papers for November 2019, we saw that this was presented to the board to consider the assurances and mitigating actions.

The trust had recently had an internal audit by Mersey internal audit assurance. This found for the time period April 2018 to March 2019 there was moderate assurance that there was an adequate system of internal control, however in some areas there was weakness in design and/or inconsistent application of controls which put the achievement of some of the organisation's objectives at risk. There were a number of recommendations which were accepted by management and actions were being implemented.

The trust was working with external stakeholders to improve the performance of the trust in relation to access and flow of patients through the hospital, but this remained a challenge for the trust which had high occupancy levels across all areas. Insufficient beds to meet the demand was on the board assurance framework with an action for a patient flow transformation programme. We observed areas being used that was inappropriate for patients to be cared for overnight. For example, the ambulatory care unit. We observed an emergency department that was at full capacity and patients having to wait in the corridor on trolleys for a long time. We became aware that at one point the hospital had run out of available trolleys and observed a patient having to wait on an ambulance trolley. It was not clear how the transformation programme was having a positive impact on access and flow.

In surgical services there were a high number of cancelled operations at the hospital, and a high percentage of these were not treated within 28 days. In the last three months of 2017 to 2018, there were 59 cancelled operations, 63% of which were not rescheduled within 28 days. Whilst from the end of that period to quarter three 2018 to 2019, the trust's performance improved but remained worse than the England average. In the final quarter of 2018 to 2019, there was a decline in performance again with 33 cancellations, 30% of which were not treated within 28 days (worse than the England average).

The trust was not meeting the constitutional operational performance standards around referral to treatment. In August 2019 the performance rate was 79.9% which was below the 92% standard and there has been a consistent failure to meet this standard, with performance varying between 78.3% and 80.7% between September 2018 and August 2019. Although the trust was not meeting this standard they had agreed to with local commissioners for the standard to be at 80%.

Delayed discharges from surgical wards had an effect on patients being able to be moved from recovery to a surgical ward.

There were a high number of patient moves during their stay which were not always part of the care pathway. A high number were after 10 p.m. at night and staff told us this was due to the demand for beds on speciality wards and at time moves to escalation areas that had been opened. Between 1 June 2018 and 31 May 2019 there had been a total of 11,838 patient moves at night, excluding transfers from the emergency department and any clinical decision units. This was around the same as the last inspection when there were 12,098. The number of patient moves at night did not appear
on the performance dashboard or the corporate risk register. This meant we were not assured that these were being monitored effectively to reduce the number of patient moves at night.

During our inspection between 8 October to 10 October 2019, there were 185 patients who were fit for discharge but were still in a hospital bed waiting for discharge. This was due to a number of reasons, for example waiting for care packages or a place in a nursing home. The trust told us that there was not a robust system in place for centrally capturing whether each of the patients declared ready for discharge then experiences a delayed discharge. They only begin monitoring when the patient has been delayed for over 21 days. Between 1 June 2018 and 1 May 2019, the number of delayed discharges across the trust were 739. This was an improvement from the last inspection when it was reported that between 1 December 2016 and 30 November 2017 there were 1657.

The number of stranded patients (in hospital for 7 or more days than required) was over the trust threshold since September 2018 to September 2019. The threshold was not more than 156 patients each month but the average monthly figure between this timeframe was 383. The number of patients whose length of stay was over 21 days was also over the trust predicted target of reducing to 107 a month by March 2020. Between April 2019 to September 2019 the average monthly figure was 189 patients. This was on an upward trajectory.

Since the last inspection the trust had set up partnership working with an external provider to release the number of beds available in the hospital for acutely ill patients. However, during the inspection we found that there was not always enough number of available beds for patients requiring a bed on a medical speciality ward. At the time of the inspection on the 10 October there were a total of 58 patients who were not on a speciality ward that was required. Also, on that day, there were a total of 51 beds across the trust which were not available for admissions or transfers due to infection.

Medical outlying patients should be reviewed daily by a member of the medical team. We checked medical outliers on a gynaecology ward and found that out of four medical patients on the ward none had been reviewed every day by the medical team. We were told that the trust procedures for medical outliers was for them not be reviewed at the weekends. However, when we reviewed the records of the surgical outliers on the ward we found that all of them had been reviewed by a member of the surgical team daily including the weekends. Following the inspection, we requested a copy of the standard operating procedure for medical outliers. This had been created in October 2019, this was when we undertook an inspection of the medical services unannounced. This standard operating procedure stated how outlying patients would be seen and did not exclude any times, for example at weekends, when patients would not be seen.

There was a discharge lounge available in the trust to help with access and flow of patients. This was to be used for patients who were going to be discharged that day and who had to wait for take home medication or transport, thus releasing beds for other patients. However, during the inspection we observed on a number of occasions that there were a limited number of patients in the discharge lounge. Senior staff we spoke with told us that the discharge lounge was used on a daily basis of around 30 discharges a day. Information provided by the trust showed that between 4 November 2019 and 1 December 2019 the average number of patients on a daily basis was 32.

To help with access and flow there were a number of bed management meetings throughout the day. We observed a number of these. Actions were identified to help with the flow of patients throughout the hospital. However, we did not observe that outlying patients were discussed even though this was on the checklist for the bed management meeting. We also checked the records
made at the time of the bed meetings between 7 October and 9 October 2019 and found out of 16 bed management meeting records checked there was only nine recorded times these had been discussed at any of the bed meetings despite this being on the checklist.

At no time in the bed management meetings we observed was the OPEL levels discussed despite this being on the checklist with actions to consider and the hospital was struggling for beds and accident and emergency department being full, with patients on the corridor. We reviewed 16 bed management checklists between 7 October and 9 October 2019 and found that there was only one recorded time of this being discussed to help inform additional actions on any occasion. Operation pressures escalation levels is a method used by the NHS to measure the stress, demand and pressure a hospital is under to help identify additional actions. For example, cancelling meetings and training to deploy clinical staff, expedite patient discharges and to work with the wider health economy.

We had limited assurances that the trust was making effective use of all the internal measures available to improve access and flow throughout the trust.

The trust was already aware of some of the constraints around access and flow and these included lack of integrated working within the integrated discharge team, lack of clarity on the discharge process and variation in ward based care around board rounds and discharge planning. The trust had recently been working on a patient flow improvement workplan and were currently working on a number of actions. For example, development of a consistent clinical criteria for primary care and to continue the twice weekly multidisciplinary team long stay review to manage delayed transfers of care. The trust had also appointed a Wirral system lead for discharge to take forward these actions but they only commenced a couple of weeks prior to the well led inspection so we were unable to assess if this had had the desired impact.

The trust had been developing a performance dashboard for health and safety performance which incorporated both ‘leading’ and ‘lagging’ indicators as recommended in best practice guidance. This included the number of non-clinical safety incidents, RIDDOR incidents and near misses for each division. This was reported to the safety management assurance committee. The majority of service areas showed an improving picture.

The trust had in place a ward accreditation scheme to measure standards and identify any areas for improvement. It was reported in July 2019; the team had inspected eight areas and six out of the eight had moved their position from level 1 to level 2 and one retained their level 2 status. Areas that required improvement were identified and actions put in place and discussed at meetings in the governance structure. One of the lower scoring areas was organisational management and this had been discussed at the patient, safety and quality board which asked for actions to improve this to be brought to a future meeting. It was noted that in November 2019 two wards had achieved level 3 status showing the wards commitment to continuous improvement.

The trust had a quality and performance dashboard against key quality and performance indicators. We reviewed information provided by the trust and found that in August 2019 it was reported that out of the 57 indicators 20 were currently failing to meet the performance threshold, 27 were on-target and eight did not yet have thresholds identified. One of the key indicators that had not met the target at any time throughout the year was discharges before noon to help flow through the hospital. The trust target was more than 33% and the highest it had been throughout the year was 19%.
There was also a workforce dashboard in place to monitor compliance. This included data on sickness and return to work, appraisal rates and medical staffing rates. This was broken down to divisional level as well as trust level. There had been a recruitment drive in the trust and an increase in the number of staff being employed. There were also alternative posts in place to help care for patients, for example pharmacy technicians on wards and advanced nurse practitioners. There were also a number of specialist nurses across the trust including consultant nurses and leads for dementia, falls and sepsis.

**Information management**

RIDDOR incidents were reported to two different committees, safety incidents that occurred outside of the ward area were reported to the health and safety committee and those that occurred inside the ward area the quality and safety committee. RIDDOR incidents were discussed at the serious incident group and we saw that these had been reported to the relevant external agencies in line with the reporting of injuries, disease and dangerous occurrences regulations 2013.

Staff had access to summary care records and this was appropriately managed. They had access to IT equipment and systems on all the wards and departments. The trust was still working towards a full electronic patient record.

The trust had established electronic prescribing and administration (ePMA) systems in place. The Global Digital Excellence (GDE) plan had been used to reduce the number of paper charts being used. For example, the neonatal unit had successfully moved to ePMA. An exemplar in ePMA implementation, the team used the system to support positive change. For example, antimicrobial prescribing must have an indication and review date, and people at risk of acute kidney injury were flagged on the system.

The trust undertook independent internal audits on data quality. For example, there had been a recent review around the quality of finance information which had identified some recommendations around the quality of budget setting which the trust was implementing.

The trust had in place a Caldecott guardian and a senior information risk officer. The senior information risk owner was accountable and responsible for information risk across the organisation. The senior information risk owner was also part of the regional network. There were regular meetings to look at information governance incidents. Two had been reported to the information commissioner’s office but they had decided that there was no further action and no systemic issues for the trust.

Board members were going to undertake cyber training and at the time of the inspection two members were on the training programme. The trust was also working with an international company to help focus on priority areas. This included a focus on phishing emails and cyber-attacks. There were posters around the trust and some staff wore pin badges.

There was a patient portal where patients could access certain results. To help maintain confidential information securely patients were only registered for the system face to face and when they had produced identification. This was used for mainly for patients with long term conditions.
The trust had a shared database as a health system management tool. The trust could use the data to target gaps in care. From September 2019 the system was live for diabetes, COPD, asthma and Atrial Fibrillation. The system included data from GP practices and the trust.

**Engagement**

The trust was continuing to build strong partnerships with other trusts in recognition for the need to work in a more integrated way across provider and partner organisations for the benefit of patients. They were beginning to look at how patient stories could influence the work of the healthy Wirral programme board.

Whilst some engagement was being undertaken, senior leaders recognised that more work was required in terms of external engagement with the wider public to inform services.

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

At the last inspection the trust held listening into action events for staff to feedback on issues or concerns they had about a particular area and to get involved in change and improvements. At this inspection this more formal process had been replaced by the ‘quality bus which was an informal listening event and sharing information and learning. The outcomes of these events were not recorded to identify any themes or trends emerging.

Patients and their relatives/carers were invited to attend meetings to share their story of the care provided at the hospital. This offered the opportunity for the trust to learn from best practice and what could be done better to improve care. We saw an example were actions had been put in place to improve patient experience of being a medical patient on another speciality ward and not always receiving a medical review. This included a review of the standard operating procedure for medical outliers.

The trust had developed a staff magazine which included articles such as the launching of the new vision and values, volunteers’ week, patient safety in washing hands and the NHS journey of a newly appointed associate director who had recently joined the trust. The magazine asked for staff to share news and stories and there were contact details for staff to send information to be included.

There was evidence of the trust undertaking public consultation in the last 12 months. This was in conjunction with other providers and was around the development of walk in centre availability.

The trust had a council of governors. There was a council of governor workshops and visits to specific areas in the hospital planned. Governors were also at meetings within the governance structure. Whilst they attended the meetings they were not involved in decision making which was in line with their role. We observed this when reviewing minutes of the meetings. The role of council of governors is to ensure that the key stakeholders – patients, members of the public, staff and partner organisations – have a say in shaping their local health service. The chair met regularly with the council of governors to keep them updated with changes, however, we found that the council of governors were not aware of the new framework for the role and remuneration of chairs and non-executive directors in NHS trusts and foundation trusts.
The director of pharmacy and medicines management and the pharmacy team had established links locally. In particular, the North West Chief Pharmacist Group and system lead for the Cheshire and Merseyside healthcare partnership. The trust had established a medicines safety public governor to support the quality and safety committee.

Since the last inspection, the trust had begun consulting more with staff on key priorities, for example the new values and behaviours and the quality strategy. The quality strategy had been sent out for consultation in December 2018 and feedback was considered before being approved by the board in May 2019.

There was a 24 hour, seven days a week matron helpline to assist patients and their relatives if they had any clinical queries and wanted to speak to a clinical member of staff.

**Learning, continuous improvement and innovation**

**Complaints process overview**

The trust concerns and complaints handling policy was in date at the time of the inspection. This was an improvement for the last inspection. This outlined the processes for dealing with a concern or complaint and the assessment of grading complaints. Different gradings were allocated different response timeframes depending on complexity. The policy also outlined that actions arising from formal complaint investigations an action plan should be put in place.

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

<table>
<thead>
<tr>
<th>Question</th>
<th>In working days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>91%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>45</td>
<td>49%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>60</td>
<td>0%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>1,384</td>
<td></td>
</tr>
</tbody>
</table>

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

The trust have reported that since July 2018 they have cleared a long standing backlog of complaints to enable timely responses to new complaints made by service users.

**Number of complaints made to the trust**

From July 2018 to June 2019, the trust received a total of 229 complaints. The highest number of complaints were for medicine, with 33.6% of total complaints, followed by Surgery (26.2% of complaints) and urgent and emergency care (14.8%).

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>77</td>
<td>33.6%</td>
</tr>
<tr>
<td>Surgery</td>
<td>60</td>
<td>26.2%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>34</td>
<td>14.8%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>12</td>
<td>5.2%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>11</td>
<td>4.8%</td>
</tr>
<tr>
<td>Core service</td>
<td>Number of compliments</td>
<td>Percentage of total</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Surgery</td>
<td>42</td>
<td>32.8%</td>
</tr>
<tr>
<td>Medicine</td>
<td>25</td>
<td>19.5%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>23</td>
<td>18.0%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>15</td>
<td>11.7%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>7</td>
<td>5.5%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>4.7%</td>
</tr>
<tr>
<td>Maternity</td>
<td>5</td>
<td>3.9%</td>
</tr>
<tr>
<td>Critical care</td>
<td>2</td>
<td>1.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2</td>
<td>1.6%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

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

**Compliments**

From July 2018 to June 2019, the trust received a total of 128 compliments. The highest number of compliments were for surgery, with 32.8% of total compliments, followed by medicine (19.5% of compliments) followed by urgent and emergency care (18.0%).

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

We reviewed 19 recent complaint files. Of the four reviewed to see if these had been responded to within the timeframe outlined in the acknowledgment letter to the complainant, only two had been responded to within the timeframe. The investigation involved the relevant persons and responses were thorough. Apologies were outlined in the response letters were appropriate. We reviewed a further eight complaint files to look at if the acknowledgement letter with the scope of the complaint investigation outlined had been sent. This had been completed on all occasions.

We reviewed seven complaints files for complaints that were upheld or partially upheld. On five occasions were learning had been identified in the response letter, the complaint file did not contain any associated action plan. Learning from experience action plans (LEAP) had been developed were themes from complaints were added to these divisional plans and divisions were responsible for implementing any actions. This was similar at the last inspection. When reviewing minutes of the patient and family experience group meetings we saw that themes from the LEAP were discussed to share learning across the trust. However, an internal audit completed looking into the complaint processes identified that although these action plans were in place these were not monitored to ensure the actions were addressed and completed. From reviewing committee and meeting papers we could not be assured that there were effective governance processes in place for the monitoring of action plans at trust level.
Number of complaints received were included in the quality and performance dashboard that was discussed at trust board meetings also the number that had been acknowledged within the timeframe. However, it did not include those that were responded to within the timeframe. On reviewing information provided by the trust before inspection in their provider information return we found that the percentage of complaints that were responded to within the agreed timeframe was 78% for 45 days or 60 days. There had been improvement over the last six months before the inspection when the percentage was 49%.

There was an annual complaints report that went to the quality committee which outlined the response times and compliance with these, but this was not seen by the board on a regular basis as part of the performance dashboard.

The chief executive officer was responsible for ensuring the trusts compliance and ensuring that appropriate action was taken following complaints that were upheld. The chief nurse had executive responsibility for the patient experience team and the head of patient experience was responsible for the handling of concerns and complaints. An example of learning from a complaint was patients with a hearing disability are now identified as part of the daily ward huddles so that appropriate adjustments can be made.

The top theme (30%) for complaints was communication failure or staff attitude followed by access and admission (27%).

Between 1 July 2018 and 30 June 2019 services at the trust received 128 compliments.

The patient experience strategy outlined complaint response target improvements but did not state how this would be achieved. The key aim was to have a patient friendly complaint process.

Accreditations

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

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

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>N/A</td>
</tr>
<tr>
<td>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td>Department of anaesthesia (trust wide)</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor</td>
<td>UKAS Cellular Pathology, Biochemistry, Haematology, Microbiology</td>
</tr>
<tr>
<td>Medical Laboratories ISO 15189</td>
<td></td>
</tr>
</tbody>
</table>

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

The finance team offered a training for non finance staff and budget holders which included budget management, business case development and standing financial instructions. The team was working towards Level 1 accreditation with the financial systems division. The procurement team had achieved Level 1 and was working towards level 2.

At the last inspection we found that the incident reporting policy had not been updated to reflect the NHS serious incident framework 2015. At this inspection, we found that the policy had been
reviewed and included the 72 hours review process and been updated in line with the NHS serious incident framework 2015.

Since the last inspection the trust had reviewed the previous meeting to discuss serious incidents and had set up a serious incident panel to decide which incidents were to be investigated using a full root cause analysis approach and agree which incidents would be declared as a serious incident. The panel met on a weekly basis and included clinical representation. At this meeting a decision was also made if the serious incident did not require any further investigation. On reviewing the notes of this meeting on 3 October 2019 the rationale for the decision to either close the incident or not to investigate further was not recorded. Whilst from reviewing the minutes of the meeting on 3 October 2019 we found that the quality of the 72-hour reviews were discussed and recorded, there was limited information recorded around any additional learning being identified. However, we did see that at the quality committee meetings information was provided on initial learning and actions from incidents and an update on the investigation.

There was a monthly safety summit meeting which looked at themes from incidents and near misses and any learning shared. Following this meeting a newsletter was circulated to staff to ensure learning was disseminated across the trust.

We reviewed the number of serious incidents that had been recorded between 1 June 2018 and 31 May 2018 and found that there had been a total of 46 recorded. This was a reduction from 120 at the previous inspection. This was due to a revised governance framework around the interventions to reduce the number of serious incidents. The trust incident reporting policy stated that incidents must be reported within one working day and the NHS Serious Incident Framework 2015 states that serious incidents must be reported within 48 hours. Out of the 46 serious incidents recorded only seven had been reported in line with trust policy and in line with the NHS Serious Incident Framework. There were a number which had taken a long time to report from when the incident had happened. For example, there was an incident which happened on 14 May 2019 which was not reported until 10 July 2019 and another incident happened on 14 December 2018 which was not reported until 21 February 2019. This meant there was a risk of missed opportunity for learning in a timely way to help prevent a further incident happening. This was the same at the last inspection.

We also reviewed the number of moderate incidents which were reported between 1 September 2018 and 30 September 2019. There was a total of 105 incidents and 13 had not been reported in line with trust policy which states within five working days or one working day if the incident is serious. From the information we reviewed only three of these were not reported in line with policy due to delays in the incident becoming known. For example, delay in diagnosis or delay in appointment. The trust policy included undertaking an audit of the processes, however, we were told this had not been undertaken for all incidents. We saw evidence that non-clinical incidents were reviewed to see if they had been managed in line with policy and serious incidents were tracked. On reviewing the performance dashboard for non-clinical incidents we found that in the monthly average for incidents being managed within trust timescales was 55%. There was no evidence that all other incidents had been managed in line with policy in terms of timeliness of reporting. This meant there was a missed opportunity for improving standards.

We reviewed six serious incident reports and found the investigator was independent to the incident. The reports identified a cause for the incident, the lessons that should be learnt from the incident, recommendations and an action plan. However, we did note that on two occasions it was not clear how the action plan had addressed all the recommendations. We reviewed a further five serious incident action plans and found that actions for learning were not always specific, measurable, attainable, relevant and time-based. None of the incident reports we reviewed identified if the
patient, family or carer helped set the terms of reference or were involved in the investigation or what support was in place for them.

Any actions identified following investigation into serious incidents were monitored at the patient safety and quality board. We saw evidence of this when reviewing minutes of the meetings.

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

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

The trust was aiming for 100% of deaths to have a primary mortality review. Following the review any further learning and a more detailed analysis would be undertaken through a structured judgement review where there was cause for concern. Between 1 June and 30 September 2019, it was reported by the trust that 75% of deaths had a primary mortality review which was an improvement for the last inspection when we found this to be just 12% had a primary mortality review.

The learning from deaths policy did not state a timeframe for reviews or structured judgement reviews to take place. This meant there was a risk that senior managers were unaware of how reviews were progressing and whether there were outlying cases with very long delays. The trust did not provide any evidence of how relatives were kept involved and informed when structured judgement reviews were underway or concluded. We reviewed 15 deaths in total. We reviewed five where a structured judgement review had been undertaken. The average time from death to primary mortality review was 65 days. There was one case were the time to undertake the review was 181 days. We reviewed five cases where a primary mortality review had been completed but no structured judgement review. The average time from death to completion of the review was 47 days. There was one case that took 114 days. We looked at a further five cases where no primary mortality review had yet been completed and the average time elapsed from death without this primary review being undertaken was 132 days.

On reviewing the five deaths that had been through the structured judgement review process we found one had a reported incident associated that was categorised as ‘no harm’. There were no others that recorded whether other incidents, complains or claims had been associated and included in the review of the death.

Mortality reviews are undertaken to look at any learning that could be implemented to help minimise the risks of any future unavoidable deaths. Mortality reviews were discussed at the patient safety and quality board. The mortality dashboard was reviewed by the mortality review steering group. The mortality review meetings took place every quarter. We reviewed the minutes of these meetings and found that learning was discussed and the use of focused reviews. The membership of the meetings was looking to include divisional nursing representation.

We saw that an in-depth review into deaths in the urgent and emergency department had been undertaken and out of 90 deaths three cases were identified as may have been a delay in treatment. This indicated that the trust was looking closely at deaths to see if any learning could be identified to improve standards.
The trust acknowledged that there was a requirement for a medical examiner in the near future and that further work was required to understand the requirements and implications for the trust. The medical examiner system is in response to observations made in the Third Report of the Shipman Inquiry. The introduction of this system will promote robust, transparent and independent scrutiny of death certification processes. They are trained in the legal and clinical elements of death certification processes.

The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. The position at the last inspection showed the SHMI to be 93 which was within the ‘as expected range’ for the trust. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. Risk is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to the England average. A score of more than 100 means more adverse (worse) outcomes than expected. The SHMI for the trust had showed a steady improvement during the last seven quarterly releases and was projected to remain in the ‘as expected range’. In May 2019, which was the last score available at the time of the inspection, it was 107.35. This was scored as green on the performance dashboard as within the trust expected range.

The trust had a planned approach to take part in national audits and shared learning. The trust participated in a total of 160 national and trust audits in the last 12 months prior to the inspection.

We asked the trust for the compliance rate with relevant National Institute of Clinical Excellence guidance. These are to reduce variation in the availability and quality of treatment and care. The trust reported that they were 99% compliant with the initial review. The guidance that they were partially compliant with (23%) had appropriate action plans in place. At the last inspection, the trust did not have a monitoring system in place, therefore, this was an improvement from the last inspection.

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

At the last inspection we saw limited evidence of research being undertaken at the trust between April 2017 and March 2018 a total of 703 patients had been recruited to take part in research. At this inspection the number had increased to 853 participants which was reported as exceeding the local research network target. The trust had some links with location universities. There was no research strategy in place, but the board of directors had already begun to discuss this.

The trust had a perioperative pharmacy team based in surgical elective admission lounge supporting perioperative care. Previously 75% of people had incorrectly managed medicines perioperatively. The number of operations cancelled due to medicines had reduced to only one in the last year. The team had also been shortlisted in the BMJ Awards in the Anaesthesia and Perioperative Medicine category. The trust had employed pharmacy staff in a housekeeping role, ensuring smart use of ‘onestop’ prescribing and reducing medicines waste by implementing a medicine returns service. This innovation had provided a trust cost saving and created two new posts.

Since the last inspection where we reported that the critical care unit needed improvement, we found that on this inspection there was a lead for governance and risks for the unit were clearly displayed.
Also, patient experience was now captured, and changes made, for example, six steps to responding to relatives and visitors who wish to gain access to the unit. To also enhance privacy and dignity an additional door had been put in place between the relatives waiting area and the main corridor to the hospital. This meant that when the door was opened for the visitors to the unit patients in the bed opposite could not be seen from the main corridor.

The trust launched the musculoskeletal integrated service on 1 July 2019. All referrals would be received electronically and triaged by advanced clinicians to the most appropriate service to meet the patient’s needs. This service was being delivered in conjunction with a neighbouring NHS community trust and new pathways were being designed around patients.

TRAC go-live technology was used by the trust in the recruitment processes. The Trac system streamlined the recruitment process and shortens the overall time it takes to recruit the right candidate to work within services.

A minilab was set up in specified areas in the trust for near patient testing. It was the first unit for the trust and one of the first in Cheshire and Merseyside to introduce point of care testing.

The trust had a service improvement team and a quality improvement team who had undertaken an external service improvement and redesign course. The team provided advice and guidance and shared appropriate tools to support teams.

The top leaders programme included a module on quality improvement techniques and this was being further enhanced to develop a trust wide quality improvement course to increase skills across the Trust and support implementation of the quality strategy.

The trust had begun to look at other organisations to help future development of innovative practice.
This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

**Urgent and emergency care**

The emergency department provides care and treatment to approximately 250 adults and 30-40 children a day. Services are provided to both adults and children for medical and surgical emergencies and trauma. The department has three rooms to manage mental health patients, including a room for patients who were brought to the department by the police under a Mental Health Act Section 136 order. Mental health liaison services are provided by a local mental health trust.

**Facts and data about this service**

The trust has one emergency department and other urgent and emergency care services at Arrowe Park Hospital. We did not include the other urgent and emergency care services as part of this inspection.

At the time of our inspection the main Emergency Department (ED) was open 24-hours, seven days a week. The paediatric ED was open from 10am to 12am Friday to Sunday and from 9am to 11pm Monday to Thursday.

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

**Activity and patient throughput**

Total number of urgent and emergency care attendances at Wirral University Teaching Hospital NHS Foundation Trust compared to all acute trusts in England, March 2018 to February 2019

From March 2018 to February 2019 there were 90,698 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

*(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 decreased in 2018/19 compared to 2017/18. In both years, the proportions were higher than the England averages.

(Source: NHS England)

**Urgent and emergency care attendances by disposal method, from March 2018 to February 2019**

- Admitted to hospital: 23,177
- Discharged*: 54,962
- Referred*: 10,950
- Transferred to other provider: 490
- Died in department: 111
- Left department#: 937
- Not known: 68

* 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?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff but not everyone completed it.

Staff told us that all training, including mandatory training was more organised since the practice development nurse (PDN) had come into post. The nurse followed up training for staff and supported them to complete their training. Staff we spoke with said that they were up to date with mandatory training.

The PDN had identified a quiet area in the department, adjacent to their office with three computers so that staff could access mandatory training at any quiet periods during their shifts. They said that training rates had improved since the area had been identified.

All but seven nurses had completed their basic life support training, of these five were booked on courses in November 2019 and one in December 2019. The six doctors who had not completed their training were booked on courses in November 2019. Additional sessions had been put on by the resuscitation officer to meet demand. The practice development nurse was booked on training for the intermediate life support instructors training to support mandatory training in the department in the future.

As well as the trust mandatory training, staff in the department completed triage training every three years, chemical training every two years and plaster skills training every three years.

Staff could not access any advanced training courses until they completed their mandatory training.

There were prizes for staff who completed their mandatory training.

Mandatory training completion rates

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

Trust level

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>104</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>102</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>95</td>
</tr>
<tr>
<td>CPR</td>
<td>85</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>85</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>84</td>
</tr>
</tbody>
</table>
In urgent and emergency care the 95% target was not met for any of the ten mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</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>Fire Safety Level 1</td>
<td>25</td>
<td>28</td>
<td>89.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>25</td>
<td>28</td>
<td>89.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling – Object</td>
<td>24</td>
<td>28</td>
<td>85.7%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>24</td>
<td>28</td>
<td>85.7%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>19</td>
<td>28</td>
<td>67.9%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security Awareness Level 1</td>
<td>16</td>
<td>28</td>
<td>57.1%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>CPR</td>
<td>16</td>
<td>28</td>
<td>57.1%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>10</td>
<td>28</td>
<td>35.7%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>7</td>
<td>28</td>
<td>25.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling – People</td>
<td>3</td>
<td>28</td>
<td>10.7%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 95% target was not met for any of the ten 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 told us that safeguarding issues were usually identified at triage. A multi-agency referral form would be completed and passed to a senior doctor in the department. There were flags on the electronic system for patients with ongoing safeguarding concerns.

The childrens safeguarding liaison team reviewed all potential safeguardings in the emergency department (ED). A report was generated about all children and young people who had attended the department. The liaison team would make referrals to health visitors and school nurses so that patients and their families could be followed up.

The department had frequent attender meetings every month to follow up on patients.

The safeguarding team came to the department to provide bespoke training for the ED staff.

Staff in the ED said that they did not always feel supported with complex safeguarding decisions especially out of hours, though they could contact the safeguarding team between 9am and 5pm.

In the emergency department review unit (ERDU) the ward manager told us that they worked closely with the safeguarding team that were based next door. They picked up domestic violence issues and
there was a question on the assessment form relating to domestic violence issues. They told us that the safeguarding nurses would often do a walk around the ward and chat to patients.

The ward manager on ERDU had the contact details of domestic violence support organisations and made referrals on behalf of patients.

**Safeguarding training completion rates**

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

**Trust level**

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

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 3</td>
<td>53</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>44</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 95% target was not met for either of the two safeguarding training modules for which qualified nursing staff were eligible.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 3</td>
<td>15</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>11</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 95% target was met for one of the two safeguarding training modules for which medical staff were eligible.

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

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and most of the premises visibly clean.

We saw that personal protective equipment was available around the department and we saw that staff used it.
There were handwashing sinks around the department and hand gel was available for use. We saw that staff washed their hands between patients and were bare below the elbow. Staff conformed to the trust uniform policy.

All but one member of staff had completed the aseptic non touch technique training for the department.

Equipment in the assessment area had “I am clean” stickers and we observed that staff cleaned trolleys, beds and equipment between patients.

In majors, some of the cubicles were visibly dirty and we saw that a vomit bowl containing body fluids was disposed of inappropriately, some of the sharps boxes were not closed, however we did not see any that were overfilled. Some however had blood stains on them.

In the childrens ED we saw that there was 100% compliance with hand washing, hand hygiene and bare below the elbow.

**Environment and equipment**

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

The modernised areas of the department, the resuscitation area, the high dependency area, the triage and minor injury area were visibly clean and tidy and uncluttered. In the majors area which was in the older part of the department there was less storage and the area was cluttered with equipment. We did see that supplies that had been delivered to the department were put away into cupboards on the same day.

Clinical equipment was set up so that multiple members of the clinical team could observe monitoring information and data for all the patients being cared for at that time.

When patients were being cared for in the corridors there was not enough room for privacy screens which affected the privacy and dignity of the patients. There were electrical outlets in the corridors so that staff could use monitoring equipment if necessary.

There was enough equipment in the department to meet the needs of the patients. There were blood pressure machines, pulse oximeters and thermometers readily available for both adults and children. Suction and oxygen were available in the cubicles and there were call bells for patients in cubicles.

We saw that call bells were available in cubicles but were not always given to patients and some patients did not have access to them at their bed side in some cubicles.

There was a Control of Substances Hazardous to Health Regulations lead for the department and new cupboards had been installed. Storage of COSHH substances had been an issue at the last inspection.

In the reverse cohort area, several toilets and showers were broken on the first day of the inspection. However, these were fixed as the inspection progressed. Some patients were unaware of where toilets and shower facilities were located.

In majors the defibrillator and resuscitation trolley had documentation showing that daily checks had been completed since the beginning of October 2019.

There were three mental health rooms. All three rooms were in use at the time of inspection, making it difficult to fully inspect the rooms, however there was enough visual access from outside to see into the rooms. None of the rooms had blind spots, room two was the only room that did not have
anti-barricade door frame in place, as such the door could not be pushed outwards or inward, only inward. There was no alarm system in situ, however psychiatric liaison unit (PLU) staff all carried personal alarms. The personal alarms, however, were credit card sized and required the staff member to locate and push a button to set off the alarm: there were no pull-cord attachment allowing for tugging the alarm to make it sound.

Each door had an observation panel, two of the doors had privacy glass that could be activated, one door did not. The rooms were free of ligature points, and furniture could seat at least four people, the furniture being of a suitable design for an assessment room. However, it was noted that police or family could take extra seating into the room, this seating was unsuitable and could be used as a weapon or tool to assault staff or others

In the paediatric area the resuscitation trolley was shared with the admissions unit. We saw that it had been checked daily and recorded.

There was a paediatric resuscitation trolley in the paediatric resus bay in the adult ED. There was documentation demonstrating that the trolley had been checked every day in October. The trolley was open and not sealed; all disposable equipment was sealed and all required equipment was present. The defibrillator had been checked on the 7 October 2019 and before that on 1 October 2019.

In the high dependency area of trolleys, oxygen cylinders were stored securely, and call bells were available in all areas. Patients had moderate access to them.

Assessing and responding to patient risk

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

The department had developed a patient safety checklist for inclusion in the patient’s paper record. There was information at the start of the checklist including patient location, investigations initiated, any pathway commenced and if a speciality bed was required. Some information and risk assessments were then completed for each hour that the patient was in the department. This included assessment of pain scores and appropriate analgesia, measurement of vital signs, any cognitive impairment, falls risk assessments, pressure ulcer risk assessments and if a call bell was in reach. As the patients length of stay in the department increased different information was required including review by a doctor, refreshments offered, a score for predicting pressure ulceration, falls assessment and administration of medicines.

At the last two inspections we had concerns that there were a number of checklists and risk assessments not fully completed. At this inspection we reviewed 16 patient safety checklists in the emergency department to check the standard of completion and found that six of these checklists were not fully completed. Although there was an improvement in completion of the pathways section since the last inspection, the sections that were not fully completed were pressure ulcer and falls risk assessments.

In the EDRU patient information was available electronically. There were alerts for patients for safeguarding and Deprivation of Liberty safeguards. Risk assessments were available and results of diagnostic tests including electro-cardiograms. During the inspection we looked at the electronic risk assessments for all eleven patients on the ward and saw that all had been completed.
The department used early warning scores (EWS), this is a guide used by medical services to quickly determine the degree of illness of a patient. We saw that EWS scores were recorded on the patient safety checklist and electronically in the patient electronic record. Patients were escalated as necessary when the scores were elevated. All staff in the department had completed the NEWS 2 training.

There was an escalation policy for deteriorating patients and patients with presumed sepsis. We saw an example where a patient was brought into the department and their condition was immediately escalated and appropriate treatment was started.

Staff in the department, particularly the resus area, had immediate access to diagnostics such as computed tomography (CT) and X-ray. The diagnostics department was linked to the ED by a direct corridor.

Consultants told us that they often stayed after midnight if they were concerned about patient safety in the department. This would be dependent on the acuity of the patients in the department and not the numbers of patients in the department. They said that 80% to 90% of the time they would stay until 1am, 50% until 2am but had always left before 4am. They said that they would put out a call for support from other consultants if they felt that they needed it and there was always a response to this. The ST4 who was on duty on one of the nights of the inspection said that they would have no hesitation about calling the consultant on call if there was an issue with patient safety.

There were always two trained nurses in the resuscitation area, which met the nurse to patient ratio standard of 1:2 set by the Royal College of Nursing.

We attended a medical handover at 8am, this was consultant led and attended by 18 junior staff. The meeting was well structured and began with roles for the day. Each patient’s plan was discussed and a description of any referrals that had been made. At the meeting we attended pain scores were discussed, where any restraint had been used for patient safety and patients who were on a sepsis pathway. The meeting finished with a “message for the day” which was read out by one of the junior doctors. These messages were prepared monthly by a consultant and displayed on the wall in the department. The message would be read out at all the handovers during that day, so all the staff got the same message. The message for that day included deep venous thrombosis prophylaxis and completion of documentation for the mental capacity act assessments.

Following the handover, the middle grade staff would have a huddle so that staff knew who was working that day, they would introduce themselves and agree on roles so that when there was a patient emergency staff arriving at the patient bedside were aware of their roles. The staff had introduced this themselves and said it worked well.

Nursing handovers and safety huddles were used to brief staff on safety issues for patients in the department.

Staff said that the trolleys area of the department could be difficult to work in as the patients in side rooms were not always visible. They did have call bells. During the inspection we saw that a nurse called for assistance with a patient and that the response was very quick; they said that help always came immediately.

The risk assessments for patients were available electronically in the emergency decision review unit (EDRU). This included early warning scores, pressure area assessment, falls risk assessments, malnutrition universal screening tool scores and pain scores. The scores changed
colour when they needed to be re-assessed or if they had not been reassessed in a timely manner so that staff always knew when risk assessments needed to be reviewed. The screens also contained information about allergies, infection alerts and any safeguarding alerts or Deprivation of Liberty safeguards.

In the EDRU patients could wait for the results of computed tomography scans in the seating area but only if the patient had been reviewed by a consultant for head injury.

There were exclusion criteria for the reverse cohort area, the area would not take any patient with an early warning score over five, any patient who required cardiac monitoring and any patient who had not been referred to a specialist team.

The ED had three dedicated mental health assessment rooms on a small corridor, separated from the ED itself by a curtain and a desk from which observations were carried out when there were mental health patients occupying the rooms. The observations were carried out by band 2 and 3 staff from the trust. Normally, there was one staff member who sat at the desk between ED and the mental health assessment rooms and they did not leave the area unattended.

There were three rooms allocated to mental health patients and one of these was a 136 suite. The police always stayed with a patient who was on the 136 suite. Security were very close to the ED and could arrive quickly on the unit if necessary.

We saw that when patients with mental health problems were admitted to the unit that a risk assessment was undertaken at triage or just after triage. The risk assessment included a RAG rating for the patient and included a RAG rating for how often they needed to be observed. There was a description of the patient so that security would know what the patient absconded.

Each day the PLU had a handover with visits to wards to discuss patients with mental health problems and their ongoing requirements.

Following the last inspection, a considerable amount of work had taken place on the unit for fire safety. A fire safety and evacuation plan had been developed with the fire warden and over 80% of the staff had undertaken the training. The PDN was working with staff for full compliance with the training. The plan was specific to the department and the band three staff were to be trained as fire wardens, there would always be one on each shift. Evacuation areas had been identified and there were plans for scenario training.

There had also been training for emergency preparedness both practical and theory with the train the trainer model used to support training.

To address the lack of childrens nurses in the paediatric ED the band seven staff in the ED had completed advanced paediatric life support (APLS) skills training meaning that there was always somebody in the ED who had APLS. Training was ongoing, and some band six nursing staff had also completed this training. The band five nurses had completed the paediatric immediate life support skills training.

Some of the adult trained nurses had completed a childrens nursing course to give them the skills to work across both adult and childrens ED.
There were two paediatric emergency medicine consultants who supported the paediatric ED. Children and young people with long term conditions had direct access to the paediatric wards.

Emergency Department Survey 2016

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.5</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>7.0</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>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.7</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)

The median time from arrival to initial assessment was consistently higher than the overall England median in all 12 months during the period from April 2018 to March 2019.

Trust performance ranged from 17 minutes to 21 minutes, compared to the overall England performance, which ranged from seven minutes to nine minutes.

Ambulance – Median time to initial assessment from April 2018 to March 2019 at Wirral University Teaching Hospital NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)
Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Arrowe Park Hospital Wirral Merseyside

From June 2018 to May 2019 the percentage of ambulance journeys with turnaround times over 30 minutes at Arrowe Park Hospital ranged from 37.4% (May 2019) to 61.5% (September 2018). The latest month, May 2019, had the lowest percentage of ambulance journeys with turnaround times over 30 minutes at 37.4%

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

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

(Source: National Ambulance Information Group)

Number of black breaches for this trust

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

From June 2018 to May 2019 the trust reported 1,773 “black breaches”. The number of black breaches fluctuated throughout the period. April 2019 was the month that saw the highest number of black breaches.

55.9% of the black breaches were due to no hospital beds being available (991).
The table below shows the breakdown of the black breaches by reason:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of black breaches</th>
<th>% of total black breaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Hospital Beds available</td>
<td>991</td>
<td>55.9%</td>
</tr>
<tr>
<td>No reasons documented</td>
<td>191</td>
<td>10.8%</td>
</tr>
<tr>
<td>Multiple ambulance attendances</td>
<td>187</td>
<td>10.5%</td>
</tr>
<tr>
<td>No Assessment Trollies</td>
<td>178</td>
<td>10.0%</td>
</tr>
<tr>
<td>No clinical assessment capacity</td>
<td>119</td>
<td>6.7%</td>
</tr>
<tr>
<td>Complex clinical handover</td>
<td>56</td>
<td>3.2%</td>
</tr>
<tr>
<td>Patient transferred to another dept</td>
<td>32</td>
<td>1.8%</td>
</tr>
<tr>
<td>Handover Input delayed due to dept pressures</td>
<td>11</td>
<td>0.6%</td>
</tr>
<tr>
<td>Multiple ambulances</td>
<td>8</td>
<td>0.5%</td>
</tr>
<tr>
<td>Total</td>
<td>1,773</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)
Nurse staffing

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

The department were working with the Emergency Care Intensive Support Team (ECIST) to look at nurse staffing in the department. A paper had been prepared and sent to the board with a number of recommendations.

They had also worked with the “Getting it right first time” team who had developed a report for the department that included information about appropriate staffing levels of nurses and medical staff in the department.

There was appropriate skill mix in the department and senior managers told us that there were no nurse staffing vacancies in the department and that recruitment was not a problem.

There were five advanced nurse practitioners in the department with another four in training. They took part in the middle grade rota and were independent prescribers. They only worked until 10pm as they could not work independently without a consultant in the department.

There were emergency nurse practitioners who worked in the department. They worked from 8.30 am to midnight. Their scope of work was dependant on their training, some could see children under 12 years of age, none of them saw children under five and they did not see patients with deliberate self harm. They were always seen by doctors.

In the EDRU there was a band six manager. There were two trained nurses and a health care assistant for the day shift and two trained staff at night though one worked the twilight shift and went home at 2.30 am; there was also a health care assistant for nights. The manager said that the nurse working the twilight shift would usually work for longer if necessary.

Staffing in the reverse cohort area was not part of the establishment and staff were taken from the ED, medicine and around the hospital to run the department.

In the paediatric ED there were not enough childrens nurses for the department and there was no rotation of childrens nurses from childrens services into the department. There were currently 2.6 whole time equivalent childrens nurses and four nurses who were in training. Some of the adult nursing staff had undertaken training in childrens nursing skills and competencies to address the gaps in paediatric nurse staffing and so there was always two nurses with paediatric training available on each shift including the night shift.

The table below shows a summary of the nursing staffing metrics within urgent and emergency care at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>June 2018 to May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual average establishment</td>
<td></td>
</tr>
<tr>
<td>Annual vacancy rate</td>
<td></td>
</tr>
<tr>
<td>Annual turnover rate</td>
<td></td>
</tr>
<tr>
<td>Annual sickness rate</td>
<td></td>
</tr>
<tr>
<td>Annual bank hours (% of available)</td>
<td></td>
</tr>
<tr>
<td>Annual agency hours (% of available)</td>
<td></td>
</tr>
<tr>
<td>Annual unfilled hours (% of available)</td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td>0.0%</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>All staff</td>
<td>220.7</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>113.1</td>
</tr>
</tbody>
</table>

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

Nurse staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness and agency usage rate.
Vacancy rates

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from December 2018 to May 2019.

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

Turnover rates

Monthly turnover rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from December 2018 to May 2019.

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

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from September 2018 to January 2019. Bank use subsequently declined in the period from January to April 2019.

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

Medical staffing

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

The department were working with the Emergency Care Intensive Support Team (ECIST) to look at medical staffing in the department. A paper had been prepared and sent to the board with a number of recommendations which included a reduction in locum staffing.

There were 12 consultants who worked in the ED, 11 substantive posts and one associate specialist. There was also a consultant who had recently retired who worked shifts to support the team.

In the week there was consultant cover from 8am to 4pm, 9am to 5pm, 11am to 7pm (this sometimes stretched to 10pm) and 3pm to midnight. At weekends there was cover from 8am to 5pm and 3pm to midnight. There was sometimes an additional shift from midday to 9pm which was generally covered between 50-60% of the time.

There were four middle grade staff on at 11am, two at 3pm, two at 7pm, two at 11pm and two at 3pm. There was a ST3 and an ST4 on duty at 11pm and 3 am.

The medical cover at night was an issue for the department and was on the risk register. There was a business plan for two middle grade staff overnight.

The middle grade rota was a problem as there were only 2.5 whole time equivalent doctors and one of these was about to leave. This meant there was a gap in the staffing of middle grade doctors which is a national issue.

The trust was adopting the Certificate of Eligibility for Specialist Registration (CESR) programme. This will help recruitment and retention in the future but is not a quick fix for the current middle
grade issues. This was part of the ECIST recommendations.

There was a training registrar rota, there were two ST3’s and five ST4 and above trainees on the rota.

There were 18 junior doctors including FY3’s who were clinical fellows; there were six FY3’s. There were no gaps in the junior doctor rota. The rota was produced every four months and included holidays, study leave and training. Doctors we spoke with said they liked the department and although it was busy they felt well supported.

The junior doctor rota had five at 11am, 10 at 3pm, 12 at 7pm, 13 at 11pm and six at 3am. Locum doctors were almost always from the internal bank and so it was very rare for an agency doctor unfamiliar to the department to do a shift.

The table below shows a summary of the medical staffing metrics within urgent and emergency care at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>0%</td>
<td>10%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>220.7</td>
<td>9%</td>
<td>13%</td>
<td>6.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>58.2</td>
<td>29%</td>
<td>47%</td>
<td>1.2%</td>
<td>70,331 (20%)</td>
<td>33,952 (10%)</td>
<td></td>
</tr>
</tbody>
</table>

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

Medical staffing rates within urgent and emergency care at the trust were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and agency use.

Vacancy rates
Monthly vacancy rates over the last 12 months for medical staff shows a shift from December 2018 to May 2019. This could be an indicator of change.

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

Sickness rates

Monthly sickness rates over the last 12 months for medical staff shows an upward trend from October 2018 to May 2019. This could be an early indicator of deterioration

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

Bank staff usage

Monthly bank hours over the last 12 months for medical staff shows a shift from December 2018 to
May 2019. This could be an indicator of change

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

Staffing skill mix

In March 2019, 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 higher than the England average. The proportion of middle career staff was lower than the England average.

Staffing skill mix for the 39 whole time equivalent staff working in urgent and emergency care at Wirral University Teaching Hospital NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>33%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>27%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>36%</td>
<td>21%</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)

Records

Staff did not always keep detailed records of most patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

There were a mixture of paper records and electronic records for patients.

Paper records were stored at the nursing stations in trolleys with keypads, the trolleys were not always locked.

We looked at 18 paper care records in the department including the patient safety checklist. Not all sections of the patient safety checklist had been completed for each patient. We saw that in the records triage times were recorded.

The patient safety checklist had been introduced in November 2018 and the department was auditing its completion of the checklist. When it had been introduced the completion rate was 21% and this had risen to 85% at the last audit. The results of the audit were reported to the trust board. Senior nursing staff told us that the form was becoming electronic in November 2019; staff would be reminded when the checklist needed to be completed for each patient and the checklist would be part of the patients electronic patient record.
We looked at three care records of children in the paediatric ED. Two were for minor injuries and the other for a child with suspected croup. All had been fully completed and we saw that one of the children who had been given steroids had been reassessed after 15 minutes had been referred to a paediatric specialist registrar.

Care records for mental health patients were recorded on an electronic system, but not the same one as the ED records. We saw that all records for the mental health patients had been duplicated on the trust system so that there was continuity and access to records for all staff. Risk assessments were completed by PLU staff, and were holistic and comprehensive. There was documented evidence in care records of PLU staff following up on referrals.

**Medicines**

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

There was a pharmacist and a pharmacy technician allocated to the ED, staff said that they were invaluable.

We checked two cupboards where medicines were stored in the ED. Medicines were stored securely in locked cupboards in rooms with key pad entry. The room temperatures were monitored, and trust policy stated that staff needed to inform pharmacy if they went above 25 degrees centigrade. Temperature readings were recorded daily and had not gone above 25 degrees in the last month.

Cupboards were well ordered and tidy. Medicines that had been opened had stickers on them so that staff were aware that they were open and the expiry date of the medicines.

Fridge temperatures were recorded, and trust policy stated that these should be in the range of two to eight degrees centigrade. Readings were recorded daily and had not gone out of range in the last month. Controlled drugs were audited every three months by pharmacy.

There were kits for anaphylaxis and hypoglycaemia which were in date. Sugary drinks were available for patients with diabetes.

There were locked cupboards for controlled drugs, one for hospital controlled drugs and one for patients own drugs. We saw that the books had been completed and signed by two members of staff appropriately. There was useful information in the cupboard relating to midazolam which was available in two strengths.

We observed that a patient who came into the ED for treatment had controlled drugs and these were stored appropriately for the patient on their arrival into the ED.

The adult ED carried a supply of medicines that could be given to children and young people out of hours when the paediatric ED was closed, this included antibiotics.

**Incidents**

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

There were three consultants who did 72 hour reviews following serious incidents. They would also pick up on incidents that might not have caused serious harm but learning from the incidents would benefit the department and prevent the incident from recurring.
There was a weekly serious incident meeting where serious incidents were reviewed across the division.

Staff told us that they received feedback if they reported an incident and that these were also discussed in safety huddles.

The practice development nurse said that they used incidents to drive training to help to support staff and to try to stop incidents re-occurring.

We saw that staff were aware of the duty of candour and the emergency nurse practitioners described how that would use if they identified a missed fracture on an X-ray.

We were told that a recent incident occurred where psychiatric liaison unit staff were assaulted in an assessment room, and although the alarm was sounded, no one came to the assistance of the staff as ED staff did not know what the alarm sound indicated. This was raised with the head of operations as a possible training area, or consideration for different alarms because the alarms did not work outside of the boundary of the ED.

**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 July 2018 to June 2019, the trust reported no serious 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 three serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from July 2018 to June 2019.

A breakdown of incidents by incident type are below:

- One apparent/actual/suspected self-inflicted harm meeting SI criteria
- One slips/trips/falls meeting SI criteria
- One medication incident meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

**Safety thermometer**

As patients were spending more time in the department there had been a focus on pressure ulcers and staff were encouraged to incident report any pre-existing pressure ulcers that the patient had on admission to the unit. There had been additional training for nurses to do skin checks to try to prevent patients developing pressure areas while in the department.

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 the 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 May 2018 to May 2019 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

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

The trust worked to guidance and pathways from the National Institute for Health and Care Excellence (NICE). They also followed guidance and recommendations from the Royal College of Emergency Medicine and professional bodies including the Royal College of Occupational Therapy and the Chartered Society of Physiotherapy.

The trust had a NICE guidance tracker so that they knew that new guidance had been implemented. The ED clinical governance meetings included an agenda item about implementation of NICE guidance and the adoption of new patient pathways.

We saw that staff accessed trust and national care pathways during our inspection.

Electronic screens in the emergency department review unit indicated if patients were on a specific pathway for example; epilepsy, diabetes, stroke.

There were shared guidelines for children and young people from a nearby specialist childrens hospital. We saw that the department was using pathways for croup and for children who were using drugs and alcohol.

The psychiatric liaison team had patient pathways for the onward referral of patients to other services.

Nutrition and hydration

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

There were vending machines in the ED for refreshments. There were also a number of cafes in the foyer of the hospital adjacent to the ED.

The patient safety checklist included information about whether the patients had been offered refreshments.

When patients were waiting in the corridors to be seen, snack bags were distributed to patients and their relatives. Staff checked that patients were not nil by mouth.

There was 100% compliance with the malnutrition universal screening tool on the emergency department review unit.

Emergency Department Survey 2016

The patient safety checklist included information about the patients pain scores and if analgesia had been administered.

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

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

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

We saw that pain relief was given to patients in a timely way and that this was recorded on the risk assessment form. The doctors discussed every patient’s pain score and pain relief at their handover.

There was a patient with learning disabilities who had poor communication skills and we saw that staff worked with the patient’s carers to understand if the patient was in pain and how they could be helped.

Emergency Department Survey 2016
In the CQC Emergency Department Survey, the trust scored 5.9 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.

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

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

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

We saw that there were action plans for the Royal College of Emergency Medicine (RCEM) audits and that these were monitored through the clinical governance meetings that were held every three months until all actions had been completed. The minutes of the meetings showed that consultant leads had been appointed for the next round of RCEM audits.

There was a clinical audit plan for the department for 2019/2020.

The allied health professionals undertook a comprehensive assessment of patients including social networks, family support and risk assessments for falls to support discharge to the most appropriate location for patient safety.

They audited each area of the ED looking at length of stay of patients and the effectiveness of their interventions. This helped to support the blended working approach and informed any training needs.

X-ray reports were audited by radiologists to check that nothing had been missed. Omissions or errors were reported through the departmental governance structures. Systems were in place so that staff could pick up any results from radiology for colleagues who were off sick or on leave so that there was no delay if a mistake had been made.
Records showed evidence-based interventions were in use by the psychiatric liaison team, with signposting towards appropriate services: we saw that patients had been directed towards memory assessment services on discharge from the hospital.

**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, Arrowe Park Hospital’s emergency department failed to meet any of the national standards.

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

- **Standard 5**: 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 5a** (fundamental): within 60 minutes of arrival (acute severe). This department: 57.1%; UK: 19%.
  - **Standard 5b** (fundamental): within 4 hours (moderate). This department: 58.5%; UK: 28%.

- **Standard 9**: Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days. This department: 85.7%; UK: 52%.

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

- **Standard 1a** (fundamental): O₂ should be given on arrival to maintain sats 94-98%. This department: 12.0%; UK: 19%.
- **Standard 2a** (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 32.0%; UK: 26%.
- **Standard 3** (fundamental): High dose nebulised β₂ agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 12.0%; UK: 25.0%.
- **Standard 4** (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β₂ agonist bronchodilator therapy. This department: 82.5%; UK: 77%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Consultant sign-off 2016/17**

In the 2016/17 Consultant sign-off audit, Arrowe Park Hospital’s emergency department failed to meet any of the national standards.

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

- **Standard 1** (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 0.0%; UK: 11%.
- **Standard 2** (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 0.0%; UK: 8%.
- **Standard 3** (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 0.0%; UK: 12%.

The department’s results for the remaining one standard was within the middle 50% of results.

- **Standard 4** (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 9.1%; UK: 10%.

(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, Arrowe Park Hospital’s emergency department failed to meet any of the national standards.

The department was in the lower 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: 14.3%; UK: 69.1%.
- **Standard 3**: O₂ was initiated to maintain SaO₂>94% (unless there is a documented reason not to) within one hour of arrival. This department: 5.4%; UK: 30.4%.
- **Standard 8**: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 4.1%; UK: 18.4%.

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

- **Standard 2**: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 59.2%; UK: 64.6%.
- **Standard 4**: Serum lactate measured within one hour of arrival. This department: 51.0%; UK: 60%.
- **Standard 5**: Blood cultures obtained within one hour of arrival. This department: 55.1%; UK: 44.9%.
- **Standard 6**: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 27.1%; UK: 43.2%.
- **Standard 7**: Antibiotics administered: Within one hour of arrival. This department: 28.6%; UK: 44.4%.

(Source: Royal College of Emergency Medicine)
### Trauma Audit and Research Network (TARN)

#### Arrowe Park Hospital

The table below summarises Arrowe Park Hospital’s performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Ascertainment</strong> <em>(Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)</em></td>
<td>75.1% - 88.7%</td>
<td>Good</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Crude median time from arrival to CT scan of the head for patients with traumatic brain injury</strong> <em>(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)</em></td>
<td>75 mins</td>
<td>Takes longer than the TARN aggregate</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury</strong> <em>(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</em></td>
<td>80.0%</td>
<td>Higher than the TARN aggregate</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care</strong> <em>(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)</em></td>
<td>33.3%</td>
<td>Higher than the TARN aggregate</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Risk-adjusted in-hospital survival rate following injury</strong> <em>(This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)</em></td>
<td>1.2 additional survivors</td>
<td>As expected</td>
<td>Met</td>
</tr>
</tbody>
</table>

(Source: TARN)
Unplanned re-attendance rate within seven days

From April 2018 to May 2019, the trust’s unplanned re-attendance rate to A&E within seven days consistently failed to meet the national standard of 5% though was consistently better than the England average.

The trust’s unplanned re-attendance rate ranged from 6.0% to 7.0% compared to the England average which ranged from 7.1% to 8.5%.

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

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

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

There was a practice development nurse (PDN) for the ED, this was a new appointment since the last inspection. They worked with new starters who were supernumerary in the department for four weeks when they started though this was flexible. Staff who had worked there before needed less preceptorship, but some staff needed more. Support was tailored to individual need. During this time staff could access trust induction, competency training and mandatory training. Preceptors were arranged for the new starters, they reported back to the practice development nurse on the progress of new starters.

We saw that training was reactive to the needs of the department, the PDN described how they would put on training following incidents in the department. They wanted to have a training agenda for the department and were working with the trust education department to support this in the future.

There was ongoing work to develop advanced skills of band six nurses who were working at night.

New staff received a core competency framework handbook. This contained information about the department and an induction checklist. The competencies for ED nurses were laid out in the handbook with a record of preceptorship and a section for practice hours, continuing professional development and a reflective account record log. These were in line with guidance from the Nursing and Midwifery Council.

There was support for staff who were having performance issues, the practice development nurse gave examples of where additional support had been given and how this had been successful.
The department had introduced breakfast clubs from 8.15am to 9.15 am every week. These were short training sessions and staff were invited in from other specialities to do the teaching sessions. These had included transfusion specialists, the acute oncology team and training for staff to apply a Kendrick splint to immobilise a limb usually following a fracture of the femur.

Two consultants from the department were also on hand to give advice and training at these times; if they had no patients they would walk round the department and were on hand to give advice and support to junior doctors and advanced nurse practitioners. They wore different coloured tunics so that staff knew that they could be approached.

Following some listening groups with staff about training 111 staff had been trained in triage. There had been 67 staff trained in plaster techniques and 63 in chemical incident management.

There were five qualified advanced nurse practitioners (ANP’s) in the department and four in training. The course comprised of two years of postgraduate training and a year of preceptorship. The ANP’s were trained by the clinical fellows in the department and there was protected learning time every week from 11am to 1 pm. They worked to the Royal College of Emergency Medicine portfolio and all the ANP’s were independent prescribers with a formulary to work to.

The emergency nurse practitioners (ENP’s) received training at a local university. They were developing their competencies and were supported by one of the consultants. They had recently done some work on ophthalmics and the use of slit lamps and the removal of foreign objects. Appraisals were split between the matron and the consultant who was the lead for the ENP’s, but the staff said that they had only completed the first part of their appraisal with the matron.

The care support workers had received training to support them when looking after patients with mental health problems. There had also been some sessions on personality disorders with three sessions lasting two hours. These were to be rolled out to the registered nurses.

A nearby specialist childrens trust supported some paediatric training for staff in the ED.

There was information on the walls around the ED for staff including information on metastatic spinal cord compression guidelines, a pneumonia reference guide and think sepsis.

**Appraisal rates**

From April 2018 to March 2019, 91.1% of required staff within urgent and emergency care department received an appraisal compared to the trust target of 88.0%.

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

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>30</td>
<td>32</td>
<td>93.8%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>26</td>
<td>28</td>
<td>92.9%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>102</td>
<td>110</td>
<td>92.7%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>15</td>
<td>19</td>
<td>78.9%</td>
<td>88.0%</td>
<td>No</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>88.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
Multidisciplinary working

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

On the reverse cohort area physiotherapists and occupational therapists worked together providing a “blended working” model. Blended working involved physiotherapists and occupational therapists having competencies from both professions and so patient assessments were normally undertaken by one member of staff unless very specialist interventions were needed. An example was that a physiotherapist could do a basic cognitive assessment on a patient and would only ask for support if a more in depth assessment was required. All competencies had been signed off.

The physiotherapists and occupational therapists worked well with the geriatricians in the ED to support safe patient discharge. They worked in partnership with primary care, community services and the local clinical commissioning group.

Patients with chronic obstructive airways disease were supported by primary care services in the community following discharge, a respiratory consultant told us that they had good relationships with primary care colleagues.

There was evidence of multi-disciplinary team working on the emergency review department. There was physiotherapy and occupational therapy support for patients when appropriate. There was also support from drug and alcohol services to support patients.

Staff in the paediatric ED said that there was better working between the women and childrens division and the paediatric ED.

There were strong relationships between the mental health trust and the trust through the service level agreement.

There were good relationships with the North West Ambulance Service (NWAS) and the ED staff. We saw that NWAS staff attended meetings and contributed to the governance of the department.

Seven-day services

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

Overnight medical cover was provided at grade ST4 level (specialist trainee) with one doctor at basic speciality trainee level (ST3) and a number of junior doctors.

There was physiotherapy and occupational therapy seven days a week. There was a business case for more hours for therapy staff.

Mental health liaison services were available seven days a week.

Diagnostic services were available seven days a week, 24 hours a day.

Health promotion

There was support available for patients from the substance misuse team, the alcohol team and the smoking cessation team.
There were flu vaccines available in the department for patients as necessary.
We saw in the childrens ED that there was information available about the measles vaccines, fireworks and sepsis. There was also an adolescent board with information pertinent to the age group.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

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

The department had completed some work with nursing homes and patients when admitted into the hospital brought their red satchel with them. This included information about the patient and if they had a “do not resuscitate order”.

On the EDRU the ward manager told us that one of the patients had fluctuating capacity. They described how they had completed the capacity assessment and how they would complete a Deprivation of Liberty Safeguard if necessary. There was also a safeguarding alert for the patient because of their fluctuating capacity.

We observed a conversation between a staff nurse and a student nurse regarding a patient’s capacity and how to manage the situation. This was thorough and well explained.

We spoke to two band six nurses who talked through the principles of the Mental Capacity Act. They were up to date with their mental capacity act and Deprivation of Liberty Safeguards training.

There was clear evidence in records for patients with mental health issues regarding capacity and consent assessment and consideration for independent mental health advocates, independent mental capacity advocates and best interest meetings.

There was information around the department about mental capacity and how to apply it.

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

Compassionate care

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

We saw that in some parts of the department that staff knew patients as they had been there before.

We spoke with a patient on the emergency department review unit, they said that they had been well looked after and their treatment had been good.

A patient who had been admitted into the majors department by ambulance said that their care had been good and they had been fully involved in the decision making about their care. Staff had provided both them and their relative with something to eat and they were waiting for a speciality bed in the hospital.

Staff told us that they did not always have time to give the care they wanted to when the department was really busy, and they were nursing in corridors.

We saw that staff remained courteous to patients even when patients and their relatives were frustrated by long corridor waits.

Friends and Family test performance

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

Response rates for Wirral University Teaching Hospital NHS Foundation Trust from May 2017 to April 2019 are shown below.

Wirral University Teaching Hospital NHS Foundation Trust – response rate June 2017 to May 2019

Response rate graph for appendices

The chart below shows the mean friends and family test scores, with upper and lower control limits. The width of the control limits are based on the response rates, therefore the higher the response rates (shown by narrower control limits) the more confidence we have in the data.

The trust scored between 7.8% and 13.0% from June 2017 to May 2019.
Emotional support

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

We heard staff reassuring patients and supporting them when they were distressed. They introduced themselves by name.

During the inspection there was a death of a child in the department. We saw that staff supported each other and that managers arranged debriefing sessions for staff.

Staff understood that some patients who were regular attenders of the department had difficult social circumstances and they supported these patients as much as they could.

A care support worker would stay in the mental health area of the department to support the patients. They would make them drinks and snacks and chat with them as a mental health assessment could take a long time. They told us that many patients were regular attenders. The workers were not allowed to leave the department when there were patients occupying the rooms.

Patients occupying the 136 rooms were always supported by a police officer.

Understanding and involvement of patients and those close to them

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

The department had done some work with the nearby specialist childrens hospital and the coroner so that if a child died in the ED they could be taken to the mortuary at the childrens trust. This was called the teddy bear pathway and allowed relatives and siblings to access the specialist bereavement services available at the childrens trust. If the death was suspicious the coroner would be asked for permission to move the patient and a police escort would be provided to accompany the private ambulance. This was a 24 hour on call service.

There was funding for families if necessary to fund transport to the specialist childrens hospital so that families were not disadvantaged by this.
A patient was admitted to the department with no verbal communication skills, we saw how staff worked with their carers to understand the patient’s needs.

One patient’s relative said that there had been delays in their care and they had not been offered refreshments. This was when the department was very busy.

**Emergency Department Survey 2016**

The trust scored better than other trusts for two of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining 22 questions.

The questions that scored better than other trusts were:
- Q14. Did the doctors and nurses listen to what you had to say?
- Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.3</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.4</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.3</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>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you</td>
<td>8.1</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>get the results of your tests?</td>
<td>8.8</td>
<td>other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.8</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>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (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 in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The emergency department (ED) had an assessment area had three bays for initial assessment, two triage cubicles, one cubicle for patients who could not easily wait in the main waiting area and four medical assessment cubicles. Staff designated one ‘hot’ cubicle in the area to undertake diagnostic tests for patients being accommodated in the corridor to assist with privacy and dignity issues. There was also a plaster room, a procedure room and an eye room with a slit lamp.

There was an eight-bedded resuscitation (resus) bay including one bay for paediatric resuscitation and one bay for major trauma. The majors area had four monitoring bays for patients of moderate to high acuity. The area was next to the resuscitation area allowing step up/down of patients.

The trolleys area had 12 cubicles for patients with moderate to low acuity and included two side rooms. Conditions that might be managed in this area included chest pain abdominal pain, simple fractures.

There was a reverse cohort area which comprised of 12 beds. This had been opened in April 2019 to alleviate some of the pressures on the ED and staff said that this had been successful. It was an extension of the trolleys area of the department and was staffed from corporate nursing and staff from ED, medicine and agency staff. At the time of the inspection the unit did not have permanent staffing but there was a business case to support this. Patients were subject to the 12 hour decision to admit to a specialty times.

There were a number of services available to support discharge for older people including discharge to assess which had been running since June 2019. There was also the rapid response team and homefirst who could fill the gap before a care package could be organised and initiated.

The emergency department review unit (EDRU) was designed to provide short-term observation and care for a maximum of two days. Staff worked closely with ED colleagues and were trained to provide care for patients with conditions such as alcohol dependence, minor injuries and anaphylaxis. There were eleven beds arranged in three bays and a side room. There was a seating area for people who were waiting for blood or computed tomography results (CT) results. There were strict admission criteria for the ward which had daily consultant ward rounds.

There was a separate paediatric with examination rooms, three side rooms and a majors room for patients who needed close monitoring. Oxygen and suction were available. There was a plaster room and a treatment room. The area had a spacious waiting room with a play area for children. This area opened on weekdays 10am to 11pm and at weekends 9am to midnight. When the department was closed paediatric patients were managed in the adult ED.

In the paediatric ED there was a controlled entrance to the department and each area had video cameras that were monitored 24 hours a day by security staff. There were physiotherapists and occupational therapists who worked in the ED. They worked from 8am to 6.30 pm Monday to Friday and 8am to 4pm at weekend. They worked closely with community colleagues.
There was a pharmacist and a pharmacy technician who were allocated to the ED. They were an independent prescriber and could give advice to patients and make changes to prescriptions as appropriate. There were satellite pharmacies around the hospital to facilitate discharge.

There was a butterfly room for patients who had died and their relatives. There was an ante room with refreshments and comfortable furnishings. If the room was in use the staff put privacy screens up in front of the room to alert staff that it was in use.

**Meeting people’s individual needs**

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

The psychiatric liaison unit (PLU) was based on site at Arrowe Park hospital. The team was from the nearby mental health trust, and was comprised of a team manager, three band 7 nurses eighteen band 6 nurses, two full time consultant psychiatrists and two part time, two specialty doctors, one psychologist with one psychologist vacancy, and a dementia team of three band 6 nurses. There was on site psychiatry from 9am to 11pm Monday to Friday and 10am till midnight on Friday, Saturday and Sunday and 24 hour cover from the team. There were two psychiatrists who were paediatrically trained.

The department had three rooms to manage mental health patients, including a room for patients who were brought to the department by the police under a Mental Health Act Section 136 order. These rooms were in a quieter area of the department. Mental health liaison services were provided by a local mental health trust.

There had been 4429 referrals to the PLU in the period October 2018 to October 2019. There was evidence of signposting to other services including older peoples mental health services and children and adolescent mental health services as appropriate,

Staff in the ED had received training from Jehovahs Witnesses about their religion and the approach to blood transfusion.

There were translation services available in the ED and staff described how and when they had used them.

The EDRU had a number of multi-disciplinary services including the substance misuse team, liaison psychiatric services and occupational therapy and physiotherapy. The unit sometimes kept older people overnight for observation and then mobilised them ready for discharge in the morning.

The EDRU had links to a number of charities that could provide support for their patients. This included domestic violence charities and homeless charities. They had links to the housing department at the local authority to provide housing support. We saw on inspection that a patient had been found a bed in a hostel. There was also a wrap-around community team that could provide support until a care package could be established for patients. Many of the patients who spent time in the EDRU had been there before.

The ward manager on the EDRU said that the ED pharmacist sometimes worked with patients with learning disabilities who were non-compliant with their medicines to improve their compliance.

Patients from nursing homes were admitted with a “red bag”. This contained patient information including a photograph and “this is me” information and their passport so that staff knew their preferences. The bags contained information about any do not resuscitate orders.
Emergency Department Survey 2016

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

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

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

Access and flow

People could not always access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

The ED opened 24 hours a day, seven days a week. This included the emergency department review unit and the reverse cohort area. The paediatric ED opened 10 am to 12 am Friday to Sunday and 9am to 11pm Monday to Thursday.

Patients were streamed in the ED on arrival. This was carried out by a qualified member of staff from the department and happened soon after the patient arrived at the department following registration. This was a change for the department as previously streaming had been carried by staff from the walk in centre and the process had been running for just over a month. Staff in the ED preferred to do their own streaming as they felt they had more control about the patients coming in to the department.

The streaming process was combined with triage and patients were generally seen within 15 minutes of their arrival in the department. The department used the Manchester triage system and was used to manage patient flow and to assign clinical priority to the patients. Following triage patients could be asked to attend other places in the hospital for treatment including the adjacent walk in centre, the eye department and the onsite pharmacy. On the day we observed streaming and triage, streaming was completed in under five minutes and triage was completed in four minutes. On one day 16 patients were streamed to other departments and on the following day 20 patients were streamed to other departments. Audits showed that the department achieved the 15 minute triage time standard on every day in July 2019. They missed the target on three days in August 2019 sometimes by half a minute and six days in September 2019 (on three days they missed the target by half a minute)

Between 9am to 5pm on weekdays the department was using the rapid assessment treatment method. This is when a patient was seen as soon as possible in the department by a senior clinician enabling time critical conditions to be identified and any intervention to be delivered rapidly. This was subject to a plan, do, study, act (PDSA) cycle where change is implemented on a small scale, the impact is assessed and there is building on the learning. They are used to improve the quality of care.

The streaming of patients, triage and rapid assessment treatment principles were based on recommendations from the Royal College of Emergency Medicine.
The department had opened a reverse cohort area to alleviate pressure in the department when it was very busy. This was a 12 bedded unit and had reduced the number of patients who were nursed on the corridor and was for patients who were waiting to be admitted to the hospital. Speciality doctors could review patients before a bed became available on the most appropriate ward. Patients were subject to the 12 hour decision to admit time. During the inspection, we observed a member of the care team arranging for a patient to stay a further night in this area which meant there was a risk that this impacted on capacity in this area and more patients waiting for care on the corridor.

There were processes in place for discharge of older people from the ED, these included the discharge to assess team, the rapid response team and homefirst that could support discharge by putting carers into patients homes until a care package could be organised. There were geriatricians who worked in the department who could fast track patients to care homes to avoid being admitted to the ED, this was particularly useful for patients at the end of life. The geriatricians said that this had reduced the number of older people being admitted to hospital.

The consultants had developed care sets for the support workers. This provided information about what blood tests and diagnostic tests were needed for each condition, we saw examples where there was one for stroke and one for chest pain. The support workers could take bloods and instigate diagnostic tests quickly. The support workers liked these and said it reduced duplication of blood tests and improved patient flow in the department.

We saw that there were sometimes significant delays in the service, these were delays in the time of arrival to receiving treatment which were over eight hours at sometimes during the inspection. Flow to the rest of the hospital did not meet demand. We saw during the inspection that there were two consultants from acute medicine and frail elderly reviewing patients in the department. They tried to provide a fast route to discharge as many patients as possible and stream other patients to appropriate investigations to support their admittance to the rest of the hospital.

Patients were regularly accommodated in corridors for extensive periods. This included elderly patients, those living with dementia and patients with mental health needs. Staff did not have the resources or facilities to deliver care with privacy and dignity.

The service used the NHS England operational pressures escalation levels framework (OPEL) to measure pressures on the service. However, there was limited focus on OPEL from the site management and capacity team during our inspection. On the last day of the inspection there was significant pressure on the ED with over 100 patients in the department. We were not assured that the actions for OPEL 3/4 were being implemented to support the department and sought assurance from the chief executive of the trust. Actions were then put in place.

Staff in the ED reported to the bed meetings but were asked to leave following their input, some said that other members of staff attending the meetings could be openly hostile to them. The OPEL status of the hospital was not discussed at the bed meetings that we attended.

We were informed during the inspection that the trust were operating at silver command. Following the inspection, we spoke with a representative from the clinical commissioning group who told us that they were unaware that the trust was operating at silver command but would have expected to be informed because of patient safety issues.

Staff told us there could be significant delays in getting speciality reviews for patients. They said that speciality doctors did not prioritise ED patients and that patients in the ED were the problem of ED. They said that ward consultants preferred that risk in the hospital was managed by the ED staff and
that was why reviews did not take place in a timely way, ED consultants said that the risk needed to be shared across the hospital to alleviate the ED pressures.

If the surgical assessment unit was full then patients were redirected to ED. As this was one of areas for medical outliers this could happen quite frequently. Patients attending the paediatric assessment unit were also redirected to ED if the unit was full. The ED could be full of patients who were inappropriate for the department. All staff were frustrated by this.

Mental health patients could wait a long time for a review. All tests and diagnostics had to be completed before a referral could be sent to the mental health team.

The consultants in the ED complained that they could not make the decision to admit patients to specialities in the hospital and that this was done by the F2 speciality doctor (junior). The clock for the 12 hours from the decision to admit only started ticking once the patient had been seen by the speciality doctor and this led to some patients waiting in the ED for long periods. During the inspection we saw that a patient had been waiting for 22 hours for a decision to admit but had not breached the 12 hour wait. These patients were under the care of the ED until the decision to admit was made.

There was a trust patient flow improvement meeting. There were actions from 2017 that had not been completed at the time of the inspection.

In April 2019, following the responsive inspection, at the trust risk meeting, the risk of patients being nursed on corridors was discussed, it was agreed that the risk would be pushed down to the department for resolution so that the trust considered that corridor nursing was an issue for the ED and not a trust problem.

There were robust discharge processes on the EDRU and staff sent out an electronic form that went directly to the patient’s GP. The form had sections for nursing and medical staff. There was a nurse discharge checklist which incorporated checks about removal of the patients cannula and if the patient had door keys to access their property.

One of the junior doctors commented that the nurses organised discharge and the doctors were expected to sign these off even if they had concerns. They had raised this with senior medical staff in the department.

We reviewed 10 paediatric patients, all had been triaged within 15 minutes and all had been seen within 50 minutes. Staff told us that the staff from the co-located paediatric assessment unit would help if the service was very busy.

**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 for 11 months over the 12 month period from April 2018 to March 2019. August 2018 was the only month in which the trust met the standard.

From April 2018 to March 2019 performance against this standard fluctuated, ranging from 44 minutes to 93 minutes. The England average for the same period ranged from 56 minutes to 66 minutes.
Median time from arrival to treatment from April 2018 to March 2019 at Wirral University Teaching Hospital NHS Foundation Trust

(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 July 2018 to June 2019 the trust failed to meet the standard and performance was consistently lower than the England average.

Trust performance ranged from 74% to 86% compared to the England average which ranged from 84% to 90% across the period.

Four hour target performance - Wirral University Teaching 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 July 2018 to June 2019 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently higher than the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Wirral University Teaching Hospital NHS Foundation Trust

(Source: NHS England - A&E SitReps).
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from July 2018 to June 2019, two patients waited more than 12 hours from the decision to admit until being admitted. Both patients waiting more than 12 hours attended in January 2019.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-18</td>
<td>315</td>
<td>0</td>
</tr>
<tr>
<td>Aug-18</td>
<td>517</td>
<td>0</td>
</tr>
<tr>
<td>Sep-18</td>
<td>653</td>
<td>0</td>
</tr>
<tr>
<td>Oct-18</td>
<td>750</td>
<td>0</td>
</tr>
<tr>
<td>Nov-18</td>
<td>790</td>
<td>0</td>
</tr>
<tr>
<td>Dec-18</td>
<td>796</td>
<td>0</td>
</tr>
<tr>
<td>Jan-19</td>
<td>971</td>
<td>2</td>
</tr>
<tr>
<td>Feb-19</td>
<td>765</td>
<td>0</td>
</tr>
<tr>
<td>Mar-19</td>
<td>729</td>
<td>0</td>
</tr>
<tr>
<td>Apr-19</td>
<td>880</td>
<td>0</td>
</tr>
<tr>
<td>May-19</td>
<td>830</td>
<td>0</td>
</tr>
<tr>
<td>Jun-19</td>
<td>532</td>
<td>0</td>
</tr>
</tbody>
</table>

(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 April 2018 to February 2019 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was lower than the England average in all months expect April 2018.

0% of patients were recorded as having left the trust’s urgent and emergency care services before being seen for treatment in nine months in the period.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - Wirral University Teaching Hospital NHS Foundation Trust

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

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

From April 2018 to March 2019 the trust’s monthly median total time in A&E for all patients was
higher than the England average.

The trust’s median total time in A&E for all patients ranged from 171 minutes to 206 minutes, compared to the England average which ranged from 146 minutes to 165 minutes.

**Median total time in A&E per patient - Wirral University Teaching Hospital NHS Foundation Trust**

(Source: NHS Digital - A&E quality indicators)
Learning from complaints and concerns

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

All complaints in the department came to the assistant director of nursing. They would look for any themes of complaints so that these could be addressed. There was learning from complaints and we saw that complaints were well managed and that lessons were shared with staff at safety huddles and electronically.

Most of the complaints to the department were about waiting times and corridor waiting. Since the introduction of streaming, timely triage and the introduction of the reverse cohort area complaints to the department had gone down.

Summary of complaints

Trust level

From July 2018 to June 2019 the trust received 34 complaints in relation to urgent and emergency care at the trust (14.8% of total complaints received by the trust).

The trust took an average of 41.2 days to investigate and close complaints. This was not in line with their complaints policy since December 2018, which states complaints should be dealt with within 30 working days.

However, the trust target for completing complaints prior to December 2018 had been 25, 45 or 60 working days (depending upon complexity).

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>9</td>
<td>26.5%</td>
</tr>
<tr>
<td>Treatment &amp; Procedure</td>
<td>8</td>
<td>23.5%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>5</td>
<td>14.7%</td>
</tr>
<tr>
<td>Medication</td>
<td>3</td>
<td>8.8%</td>
</tr>
<tr>
<td>Documentation</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>Transfer &amp; Discharge</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>Access &amp; Admission</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>Medical Device / Equipment</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Infection Control</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Disrupt./Aggress. Behaviour</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>34</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

From July 2018 to June 2019 there were 23 compliments about urgent and emergency care at the
trust.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The emergency department (ED) was part of the medicine and acute care division.

Following an anonymous whistle blowing about bullying in the ED at the end of 2017 a listening exercise had taken place with independent consultants shadowing staff and conducting a significant number of staff interviews. This had led to a cultural review of the department in 2018. Six areas had been identified in the review for action these were training including clinical training, leadership training and job related training, agreed behaviours for staff, the health and wellbeing needs of the staff, awareness of improvement work related to patient flow and departmental management and leadership structure.

There was improved visibility of the leadership with walkabouts from the triumvirate and executive team visits and shadowing. The review had led to the current management structure of the department with an assistant director, a quality matron with a remit around incidents and governance and an ED manager with a remit round the day to day running of the department including duty rosters and staff recruitment.

The two managers/matron and the assistant director worked well together, they had operational oversight of the department and were aware of the risks and issues of the ED. They were visible in the department and the matron and the manager went into the department every day. When the department was busy they supported the staff in the department. They worked hard and were proud of the improvements that had been made. They were frustrated because they had put in a significant amount of work to improve patient safety in the department but there was nothing else the department could do to improve flow through the hospital.

The emergency nurse practitioners told us that the leaders in the department were more visible and more approachable.

Staff told us that they felt supported by their managers and that they were listened to.

There was coaching for top leaders as part of the Top Leaders Programme and this was being devolved down to shift leaders

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy. However we did not see any evidence how this strategy was going to be turned into action or how this was going to be monitored. The vision and strategy were focused on sustainability of services.

There was a strategy for the department which included access and flow, workforce and quality and safety. This was for 2019/2020. However, we did not see any evidence that there were workable plans to underpin this strategy with key actions, milestones, and accountability identified or how this was going to be monitored.

The department were to receive capital funding from the government and there were plans to redesign the department. Managers told us that they wanted areas to enable care of very complex patients and a better environment for patients with dementia and cognitive impairment.
The consultants were working towards a better staffing model, particularly around medical cover at night. They were looking to expand the clinical fellows programme and were developing a five year plan.

Work was ongoing across the region looking at regional paediatric urgent and emergency medical cover.

**Culture**

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

We observed that all members of the department worked cohesively together from the consultants to the health care assistants. Everyone was aware of their role and what needed to be done for the patient.

Staff told us that they enjoyed working in the department even though it could be very busy. They said that staff worked together as a team to do the best that they could for patients. They said that the culture had improved with the new leadership team.

The department had invested in additional training for staff and staff told us that they felt invested in and valued. Managers said that this had helped with staff retention and improved morale,

The advanced nurse practitioners said that they felt supported and valued in the department. They said the role was well established in the department.

Staff told us that morale had improved since the ED were doing the streaming at the front door with two staff on triage. They said they thought this system was safer than the previous system. They also said that the opening of the reverse cohort area had improved morale as this was a better environment in which to care for their patients. Staff had a “can do attitude” towards improving patient safety.

A care support worker told us that they had been accepted for an apprenticeship in the department, they were really pleased as they loved working in the department.

**Governance**

Leaders operated governance processes, throughout the service and with partner organisations. However, these were not always effective. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The division was divided into four directorates each with its own triumvirate of leaders and governance structures. Divisional patient safety and quality boards had a representative from each directorate. The clinical directors, medical director and divisional director met weekly as a leadership team to review performance.

Managers attended a monthly divisional performance review meeting where key targets and patient flow were reviewed, as well as the divisional dashboard. Information from patient safety and quality boards and the harms panel reports were also reviewed at the performance review meeting.
As part of the governance structures with partner organisations, the service used the NHS England operational pressures escalation levels framework (OPEL) to measure pressures on the service and put in place actions to help mitigate risks. However, this was not always used effectively. We observed during the inspection, significant pressures in the department and the OPEL levels were not discussed as part of the bed management meeting or by the department who attended the meetings. This meant we were not assured that the governance system in place was being effectively implemented to support the department.

There were systems put in place by the divisional team who had senior oversight of the department which were not always effective. We found areas that were on full capacity, for example assessment units, patients were being directed to the emergency department which was also full to capacity.

The service has put in place a reverse cohorting areas which was opened to help alleviate pressures in the emergency department area. This was to enable patients, who had been assessed as requiring ongoing care, to wait for that care to be delivered. However, we found that this was not always being used effectively as patients had been in the area overnight. Also, this was staffed at times by other areas of the hospital on a rota basis and there was not a staffing establishment allocated to this area at the time of the inspection. This meant there was a risk that important changes in a patient’s condition, or their planned care did not happen in a timely way due to constant staff changes.

Effective management of the environment and equipment did not always take place. For example, we found broken toilets and showers that had not been through the governance systems effectively to ensure they were available for patients.

Matrons reported oversight by the triumvirate at divisional level had improved and governance structures were stronger, they stated governance meetings were useful and involved all members of the team to improve risk management. Managers told us the service ‘felt safer’ as governance structures supported them to manage quality, safety and performance in the service.

There was an emergency department governance meeting that was held every month in the department. This was well structured and well attended by doctors and nurses and pharmacists. All deaths in the department were discussed and one of the agenda items was how the department had worked with the ambulance service about transfer of a patient when they had a cardiac arrest and how the trust needed to review their policy.

New guidance and pathways were agenda items and there was discussion about a pathway for low risk chest pain on the emergency department review unit, there was debate about the age criteria and it was agreed to undertake an audit to determine the cut off age.

There was a clinical governance newsletter which was written by one of the consultants in the department. It was well written and contained case vignettes taken from root cause analyses, reviews and incidents. There were learning points relevant to the department for all staff. There was a good news corner with thanks to staff who had gone above and beyond to support patients and their relatives at difficult times during their treatments and staff who had stepped in at short notice to cover shifts and examples of strong leadership.
Management of risk, issues and performance

Leaders and teams used systems to manage performance. However, they were not always effective. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, there were times when these had not been implemented in a timely way. They had plans to cope with unexpected events.

We asked for copies of action plans to help improve patient outcomes following national audit results. We were only provided with an action plan for asthma and consultant sign off despite there being other national audits were the service did not meet the standard. For example, the severe and sepsis shock audit outcomes.

There were areas where performance standards were well below national standards which had not improved significantly since the last inspection. For example, delays in time of arrival to receiving treatment which we observed during the inspection, could be eight hours. During the inspection we saw that a patient waited for 22 hours for a decision to admit. The Royal College of Emergency Medicine recommends that the time patients should wait from the time of arrival to meeting receiving treatment should be no more than one hours. The service did not meet this performance standard for 11 months out of 12 between April 2018 and March 2019. This meant that we were not assured that performance was managed effectively at the time of the inspection.

Whilst there had been an improvement in the performance of completion of the safety checklists and completed risk assessments this still required improvement. We found areas where these were still not being completed despite an audit process in place.

There was a trust patient improvement meeting which the department and division fed into and actions had been put in place to implement within the department. There were actions from 2017 that had not been completed at the time of the inspection to help improve performance within the service.

If a risk was identified in the department the risk management department was responsible for ensuring the risk was added to the divisional risk register. Managers told us the risk department followed up any actions either on the review date identified or after six months. However, the divisional director of nursing and senior nurses met weekly with the divisional risk management team to review severe and moderate risks and escalated these to the divisional risk committee through the patient quality and safety board. The weekly associate director of nursing reports identified all incidents and outstanding risks, and a risk reminder was sent electronically to risk owners to highlight when an action was due.

There was a trust risk meeting where each division presented their highest risks so that the trust was aware of departmental and divisional risk.

Managers and leaders attended a daily divisional safety huddle which included a review of incidents, risks and staffing for the previous 24-hours and the next 24-hours.

Managers and medical staff were aware of the risks in the department and worked to mitigate the risks.

Departmental risk was an agenda item for the governance meeting. Risks and any actions were reviewed including any root cause analysis actions. New risks were discussed. There was a patient safety section with clinical incident themes and any trends for information. Items for information sharing were discussed.

There was a consultant lead for mortality reviews. A list of all deaths in the department was produced every month and this was shared with the coroner. Each case was allocated to a
consultant who reviewed the patient record. The cases were then graded into no concern or need of a further investigation. These cases were then discussed at the monthly mortality reviews which fed into the trust mortality reviews. Lessons learned were then disseminated to wider teams by email, the nursing safety huddle, monthly clinical governance meetings and a bulletin written by the ED mortality lead. Whilst the mortality review process was well embedded in the department there were occasions when there was a delay in undertaking a primary review. This meant there was a missed opportunity for timely learning to improve standards of care.

There was a ward accreditation scheme and we saw that the emergency department review unit (EDRU) had been rated as amber, they had missed the green rating by one point.

Information management

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

There was a quality dashboard for the medical directorate. There was information about the directorates performance in the domains of safe, effective, caring, responsive and well-led, this was for managers and staff.

We saw that data was available to managers and staff in the department. There was data collection to support access and flow to the department. The ED were using the “getting it right first time data” and the emergency care intensive support team to support the development of the department.

There was a mortality dashboard to support learning from deaths.

There was ongoing development of a joint dashboard for the trust and the psychiatric liaison team.

We saw that staff logged out of computer screens when they walked away from them, there were signs around the department advising staff to do this.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The department had engaged with staff as part of the cultural review through a staff survey. This had resulted in several actions for improved communications including a newsletter and a staff suggestions scheme.

As part of the cultural review the department was working with staff to agree acceptable behaviours in the department and staff were to be involved in agreeing a values and behaviour statement for all staff to adhere to. There had been work around anti bullying and harassment with training for all staff.

The department had made some changes to support staff wellbeing. This had included staff room improvements and water bottles for staff. There were health and wellbeing sessions and an emphasis on staff taking breaks. Training was given for resilience and there was mindfulness training and debriefing training. There were plans for further health and wellbeing activities.

There was to be input from a mental health charity and counselling sessions to support staff.
We saw that staff were told to take their breaks by the senior staff in the department. There was good staff engagement with nights out and social events for the department. Staff told us that there were two Christmas parties so that staff could choose which one they wanted to attend depending on cost.

One of the local Members of Parliament had been critical of the unit in the press and so staff from the department had written back and invited them into the department. They said this had given closure to the incident.

Learning, continuous improvement and innovation

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

The practice development nurse had made a significant difference to training and development in the department so that staff were competent to deliver services. They were looking to develop a less reactive approach to training and development once all staff were trained.

The departments used a range of quality improvement tools such as plan, do, study, act to test out improvements. This was part of the department culture and supported improvements.

The department was working with external agencies to drive improvement of care and quality.

Wirral University Teaching Hospital NHS Foundation Trust

Medical care (including older people’s care) evidence appendix

Arrowe Park Hospital
Arrowe Park Road
Birkenhead

Tel: 0151 678 5111
www.wuth.nhs.uk

Date of inspection visit: 8 October to 14 November 2019

Date of publication: 31 March 2020

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.

Medical care (including older people’s care)

Facts and data about this service

The medical care service at Wirral University Teaching Hospital NHS Foundation Trust provides care and treatment for geriatrics, diabetics, cardiology, gastroenterology, respiratory, endoscopy, dialysis, dermatology, rehabilitation, haematology and nephrology. There are 503 medical inpatient beds located across 20 wards/units; Ward 25, 21, 22, 23, 24, 26, 27, 30, 32, 33, 36, 37, 38, MSSW, OPAU, AMU, CCU, Ward D1, M1 and CGH Rehab.

The trust provides acute services from two sites:

- Arrowe Park Hospital: 421 beds are located within 17 wards/units
- Clatterbridge Hospital: 82 beds are located within three wards

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

The trust had 50,464 medical admissions from March 2018 to February 2019. Emergency admissions accounted for 26,192 (51.9%), 1,383 (2.7%) were elective, and the remaining 22,889 (45.4%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 11,865
- Gastroenterology: 10,216
- Geriatric medicine: 8,077

(Source: Hospital Episode Statistics)

During the inspection we visited all medical care wards. We also visited ward one surgical day case unit, urgent medical assessment unit and the discharge lounge.

We spoke with 78 members of staff including senior managers, members of the infection prevention and control team, ward sisters as well as registered nurses and doctors, therapy staff and health care assistants. We also spoke to 16 patients and relatives.

We observed care and treatment and looked at 15 patient care records and 82 electronic medicine administration records as well as service performance data.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to staff. However, not all staff completed it.

Mandatory training completion rates

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

Trust level

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>462</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>461</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>408</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>144</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>396</td>
</tr>
<tr>
<td>CPR</td>
<td>388</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>377</td>
</tr>
<tr>
<td>Fire Safety Level 2</td>
<td>369</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>308</td>
</tr>
<tr>
<td>Data Security Awareness Level 1</td>
<td>301</td>
</tr>
<tr>
<td>ILS</td>
<td>8</td>
</tr>
</tbody>
</table>

In medicine, the 95% target was not met for any of the 11 mandatory training modules for which qualified nursing staff were eligible.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Fire Safety Level 1</td>
<td>104</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>101</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>99</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>90</td>
</tr>
<tr>
<td>CPR</td>
<td>89</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>83</td>
</tr>
</tbody>
</table>
In medicine, the 95% target was not met for any of the nine mandatory training modules for which medical staff were eligible.

**Arrowe Park Hospital**

Staff received mandatory training, however not all staff kept up-to-date with all mandatory training modules. The service set a stretching 95% target for completion. Staff did not meet this in any module, with medicines management and data security training compliance low for both medical and nursing staff. Completion rates for nursing staff were above 75% in five out 11 modules and for medical staff in three out of nine modules.

We could not be assured the information given by the trust was an accurate reflection of completion rates as the trust could not map staff to individual locations within the trust.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td></td>
<td>420</td>
<td>472</td>
<td>89.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td></td>
<td>420</td>
<td>472</td>
<td>89.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td></td>
<td>372</td>
<td>472</td>
<td>78.8%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td></td>
<td>124</td>
<td>164</td>
<td>75.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td></td>
<td>355</td>
<td>472</td>
<td>75.2%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td>351</td>
<td>472</td>
<td>74.4%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td></td>
<td>341</td>
<td>472</td>
<td>72.2%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Level 2</td>
<td></td>
<td>330</td>
<td>472</td>
<td>69.9%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td></td>
<td>275</td>
<td>472</td>
<td>58.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security Awareness Level 1</td>
<td></td>
<td>265</td>
<td>472</td>
<td>56.1%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>ILS</td>
<td></td>
<td>8</td>
<td>33</td>
<td>24.2%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine, the 95% target was not met for any of the 11 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety Level 1</td>
<td></td>
<td>97</td>
<td>111</td>
<td>87.4%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td></td>
<td>93</td>
<td>111</td>
<td>83.8%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling – Object</td>
<td></td>
<td>91</td>
<td>111</td>
<td>82.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td></td>
<td>83</td>
<td>111</td>
<td>74.8%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td>82</td>
<td>111</td>
<td>73.9%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td></td>
<td>76</td>
<td>111</td>
<td>68.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
In medicine, the 95% target was not met for any of the nine mandatory training modules for which medical staff were eligible.

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

Following our inspection, the service provided information that showed compliance with basic and intermediate life support training as:

<table>
<thead>
<tr>
<th>Level</th>
<th>Nursing staff completed</th>
<th>Medical staff completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic life support</td>
<td>90.15%</td>
<td>74.17%</td>
</tr>
<tr>
<td>Intermediate life support</td>
<td>43.9%</td>
<td>Not required</td>
</tr>
</tbody>
</table>

The trust was aware of low compliance rates with resuscitation training and we saw this was on the trust risk register. A paper was presented to the patient safety and quality board in June 2019, this included an action plan for each division to improve compliance levels. This showed the service had trajectories in place and ward sisters used coloured booklets to monitor training dates. Progress against the action plan was monitored weekly by matrons. However, the action to have a trajectory in place was still rated red. The service had improved compliance for nursing staff for BLS and ILS in quarter one, but at the time of our inspection compliance with intermediate life support training remained low.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers received a monthly report on mandatory training compliance in their area, which they used to alert staff to training they needed to complete. This was also discussed in annual appraisals with staff.

The mandatory training was comprehensive and met the needs of patients and staff. It was delivered through face to face sessions and online training. The service had two practice education facilitators who supported staff to access and complete mandatory training.

Safeguarding

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

Safeguarding training completion rates

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

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in medicine is shown below:
In medicine, the 95% target was met for one of the three safeguarding training modules for which qualified nursing staff were eligible. This was based on only one staff member completing the protecting vulnerable people level 1 training module.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>68</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 3</td>
<td>26</td>
</tr>
</tbody>
</table>

In medicine, the 95% target was not met for either of the two safeguarding training modules for which medical staff were eligible.

**Arrowe Park Hospital**

Most nursing staff received training specific for their role on how to recognise and report abuse. Though the service had not met the trust target compliance rates were above 85%.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at Arrow Park Hospital for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 3</td>
<td>162</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>261</td>
</tr>
</tbody>
</table>

In medicine, the 95% target was not met for either of the two safeguarding training modules for which qualified nursing staff were eligible.

Most medical staff received training specific for their role on how to recognise and report abuse. Though the service had not met the trust target compliance rates were above 75%.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at Arrow Park Hospital for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>60</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 3</td>
<td>26</td>
</tr>
</tbody>
</table>

In medicine, the 95% target was not met for either of the two safeguarding training modules for which medical staff were eligible.
Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with could give examples of potential safeguarding issues and how they would escalate these.

The service used an umbrella symbol in patient electronic notes and above the bed, so staff could easily identify patients where a safeguarding alert had been raised.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They were supported by the internal safeguarding team and knew how to make referrals to local authorities. Staff escalated safeguarding concerns to the safeguarding team through the electronic patient record and the safeguarding team updated records to provide feedback to staff. Managers told us the safeguarding team would offer additional safeguarding training, if required to staff.

However, staff and managers also told us that the support from the safeguarding team did not meet their needs. They stated the team was not visible for support on the wards and did not offer sufficient support to staff to raise concerns and follow these up.

Managers monitored completion of safeguarding referrals through perfect ward audits. These included a paperwork audit and talking to staff to check their understanding of safeguarding referral processes. The safeguarding audit of ward 37 in August 2019 showed 94.9% compliance.

**Cleanliness, infection control and hygiene**

The service did not always control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection. Not all equipment and areas of the premises were kept visibly clean.

Staff did not always follow infection control principles. We saw most staff washed their hands before and after providing care using the World Health Organisation five moments for hand hygiene. Most staff followed ‘bare below the elbows’ guidance. However, we observed staff did not consistently wash their hands or use hand gel before providing patient care on ward 23 and the medical short stay ward.

Ward areas were generally clean and had suitable furnishings which were clean and well-maintained. Patients we spoke with, told us they were satisfied with the cleanliness of the wards. In some areas, staff cleaned equipment after patient contact and labelled equipment with ‘I am clean’ labels to show when it was last cleaned.

However, on ward 21 we found clinical equipment such as bladder scanners did not have any indication if they had been cleaned or not. On ward 26, we found two shower rooms with standing stale water in the base of chairs and the shower basin and with toiletries scattered on the floor. On the medical short stay ward, we saw the sink in the relatives room was not clean and had a blue substance dripping from the taps.

The service used cloth curtains at each bed space. There was no schedule for the frequency of curtain changes. We spoke to hotel services who told us curtains were changed as when required and after an infection had been identified in the bed space.

The service was supported by a dedicated infection prevention and control (IPC) team. However, at the time of our inspection there were no link nurses for medical care services in place. The IPC team had a 24-hour on call service for wards to offer advice and guidance on infection prevention and control on the wards. However, staff told us this was not always used by staff in decision making out of hours.

The decision to reopen areas following an infection outbreak was made by the executive team, with advice from the IPC team and consultant microbiologist. A member of the IPC team attended the
bed management meetings. Staff told us this advice was not always acted on and bed managers would over rule ward staff decisions not to open areas and did not always involved the IPC team.

During our inspection, we saw a six bedded bay on the older persons assessment unit was opened at 11pm though the ward had been closed to admissions that day due to norovirus. The decision was made by senior managers due to the high number of patients waiting for beds in the emergency department. However, the IPC team were not called and the next day they closed the ward to admissions again as it had not been infection free for 48 hours. We saw there were no signs at the entrance of the ward during the infection outbreak asking visitors to take additional infection control measures.

Staff also gave an example of a patient on ward 36 who was moved into a closed bay from an area which had an infection risk by bed manager against the advice of the ward sister.

Staff in the IPC team told us ward staff were good at reporting incidents of risk of infection or actual infection. They also proactively found infection incidents by tracking and monitoring patients with infections. However, staff told us they did not always get feedback after reporting an incident.

The IPC team conducted an annual IPC audit on each ward. The last audit flagged wards 24 and 36 as having compliance with infection prevention and control measure below 70%. An action plan had been put in place for both these wards. Matrons also monitored compliance with infection prevention and control measures through the perfect ward audit.

The service had an outbreak of clostridium difficile in 2019. Following the outbreak, the service implemented an action plan and held weekly outbreak meetings attended by IPC team, ward sisters, matrons, estates and facilities and the chief nurse. The service had developed ward specific improvement plans and at time of inspection no ward was on an improvement plan and the outbreak was declared closed.

We reviewed the infection prevention and control action plan and saw some actions due for completion at the end of September 2019 were rated red. These included, replacement of damaged equipment that could not be effectively cleaned, ensuring all waste bins were fit for purpose, repositioning floor graphics to move trolleys off corridors and removing out of use televisions. There were also a number of measures with no rating or progress indicated on the action plan such as reviewing the admission criteria to the infectious diseases ward, reviewing the personal protective equipment policy and reviewing and simplifying the cleaning procedure following patient discharge.

The audit following implementation of the clostridium difficile action plan was conducted by the IPC team. The team told us if they identified any issues these would be shared with ward sister to action and a re-audit would be conducted. We reviewed audit scores before the action plan and after the improvement plan was implemented. We saw that of 17 areas audited compliance had declined in five areas and two areas were not audited following the implementation.

The service held a serious incident panel to review all deaths where clostridium difficile was identified. This was attended by clinical leads, associated directors of nursing, the risk team, the legal team, complaints and health and safety matrons. These were cross divisional to ensure learning was shared across the hospital.

There was a trust wide action plan in place for environment and estates issues which identified minor works and targeted environment work on wards. Every ward had an environmental improvement plan.

At the time of our inspection the ward used as a decamp facility, to allow bays to be deep cleaned, was used as the reverse cohort area in emergency department. This meant there was nowhere to move patients to if the bay required deep cleaning or fogging. Fogging is the spraying of disinfectant
to reduce airborne and surface bacteria. We saw this was on the risk register for the service with a review for April 2019, but no actions had been updated.

Patients with an identified infection were cared for on a dedicated infectious diseases ward. This had specialist single rooms and bays. Rooms for patients with clostridium difficile had an anti-bay with sink, personal protective equipment and wipes and the rooms and bays had ensuite toilets and showers.

Patients were screened on admission for carbapenemase producing enterobacteriaceae (CPE). However, the service did not have a screening policy. This meant staff did not have clear guidance on CPE screening. The service did not use rapid detection swabs for CPE screening.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Hotel services conducted a monthly audit of cleanliness and cleaning records. The results of audit were displayed at the entrance of the ward and shared with the IPC team. We reviewed the audit results for July to September 2019 and saw the average compliance rate was 97.8% with all wards scoring over 96%.

The IPC team proactively promoted infection control measures on ward. They had a ‘clean between’ campaign which encouraged staff to follow infection prevention and control measures between caring for different patients. The team had a plan of events on the wards for the forthcoming infection control awareness week.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment generally kept people safe. However, some areas and equipment were not properly maintained or fit for purpose.

Patients could reach call bells and staff responded when called. Some patients we spoke with told us that staff came when they rang for help. However, others told us they had witnessed delays in staff response when other patients had used the call bell. On ward one, staff told us the call bell system was old and often broke down. We saw that a risk regarding the age and reliability of call bells on ward 36 was recorded on the risk register with target date for action plan completion of 2029. Managers told us if the system broke down they did not use the bed space to ensure patients were safe.

The design of the environment did not always follow national guidance or best practice. For example, the discharge to assess team office was based within the bay area of the discharge lounge. This meant there was a risk patients could overhear confidential conversations about the care and treatment of other patients. During our inspection, we saw telephone conversations about patients took place in this area and confidential patient paperwork was left on desks in this area that was unattended. This was an issue we raised at our last inspection.

We found broken shower and toilet facilities on three wards. On ward 32 a toilet and shower room for patient use had a sign stating not to lock it as the lock was broken. This meant that patients could not use this and maintain privacy and dignity. We found out of order toilets and bathrooms on ward 21, 22 and 26. On the acute medical unit the cover below the sink in the bathroom had fallen on the floor and was a trip hazard.

At our last inspection we found sluice rooms which stored substances hazardous to health and urine samples were not locked. During this inspection we found store rooms unlocked on wards one, 23, 25 and medical short stay ward and they contained antiseptic skin cleanser, descaler and alcohol hand gel. On ward 23 we found a urine sample on a shelf in an unlocked store room. Health and
safety best practice guidance on the storage of substances hazardous to health is that they are kept in a secure cupboard or store room.

On ward 32 the resuscitation trolley was kept in locked clean store room. There was a notice on door telling staff not to lock it but at the time of our inspection the room was locked. This meant there may be a slight delay accessing life saving equipment in an emergency.

Health and safety best practice guidance is that oxygen cylinders should be stored securely in a well-ventilated storage area or compound when not in use. We found full and empty cylinders stored together and not secured on wards 22, 26 and 32 and the discharge lounge.

Following our last inspection, we told the service it should ensure that emergency equipment has the appropriate portable appliance tests carried out. At this inspection we found not all equipment was regularly maintained. The portable appliance test sticker on the defibrillator in the discharge lounge indicated it had not been tested since March 2018. The label on the suction machine indicated it was last tested in August 2018. The test label on the patient fridge in the medical short stay ward did not clearly state the month of testing and was last tested in 2018. On the acute medical unit, tests were overdue on a blood pressure monitor and an aura scope. We reviewed the policy on portable appliance testing which stated that the frequency of testing should be based on a risk assessment to include type of equipment, location and past test results.

On ward 26 we found personal protective equipment was balanced on a side rail outside a bay where it could easily fall onto the floor.

Most fire exits were kept clear and staff had received training on using new evacuation equipment. However, exit for beds from ward 21 via ward 20 had been left open and the domestic trolley was in the way. This was moved during our inspection. However, there was also a desk and table in the corridor near the fire exit which could impede the movement of a bed through that exit.

On ward 25 the exit was temporarily blocked by a painters trolley. This was corrected whilst we were on the ward. The workman had entered ward and placed trolley there without alerting staff, so staff were not aware of the temporary blockage.

However, the service had enough suitable equipment to help them to safely care for patients. Managers told us the service had invested in new equipment since the last inspection. We saw the environment on ward one had improved with toilet and shower facilities available and new patient lockers and chairs.

The service had made improvements to the environment in the discharge lounge since our last inspection, with new sky lights and lit picture frames.

Leaders told us there was a three-stage programme for estates improvement and as part of stage one minor worked had been completed on wards 32 and 36. Improvement works to facilities on ward 25 were taking place during our inspection.

Staff carried out daily safety checks of specialist equipment. Since our last inspection the service had invested in new resuscitation trolleys. These were stored in accordance with Resuscitation Council (UK) guidelines with tamper-evident seals. We saw daily, and weekly checks of the resuscitation trolleys were completed. Staff completed defibrillator portable appliance tests. Staff recorded the tag number of the tamper-evident seal each time it was changed. The service had suitable facilities to meet the needs of patients’ families.

Staff disposed of clinical waste safely. Staff used sharps bins appropriately.

Assessing and responding to patient risk
Staff did not consistently complete and update risk assessments for each patient. However, staff identified and quickly acted upon patients at risk of deterioration.

Staff did not consistently complete risk assessments for each patient on admission or arrival or review risk assessments after any incident. For example, we found one patient record on ward 19, where the falls risk assessment was not fully completed and had not been updated following an unwitnessed patient fall. We also found a patient at risk of pressure ulcers on the ward with some reddening had no repositioning chart completed for two days. Another patient’s record had no lying and standing blood pressure completed.

The trolley area in urgent medical assessment unit was used as a five bedded bay overnight. We reviewed risk assessments and patient rounding for three patients and saw two had no fluid balance chart completed or record of food or drink intake. There was only one record of patient focussed rounding in two patient records which had taken place late at night. Patient ‘rounding’ is a process of regular nursing checks to ensure patient’s fundamental care needs are being met.

Managers told us the service had a plan to improve delirium and dementia screening as this was not consistently completed. In ward board rounds, ward sisters reminded doctors to complete delirium and dementia screening for patients.

We reviewed the records for three patients on ward one, none had the nutritional risk assessment completed since moving wards.

Staff did not always share key information to keep patients safe when handing over their care to others. The trust policy stated a situation, background, assessment and recommendation (SBAR) template should be completed when patients were transferred to an escalation area or between wards as a medical outlier. Staff we spoke with told us some wards were using their own template not the SBAR handover template outlined in the policy. We reviewed the notes for three patients on ward one, which was an escalation ward. We found that one had no SBAR completed, one had an incomplete SBAR and one had an incomplete SBAR not on the trust template.

The service told us there was a standard operating procedure for all escalation areas with an accompanying risk assessment checklist. We requested the procedure and completed risk assessments. However, the service did not provide these.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used an electronic system to record observations completed using the National Early Warning System (NEWS2). We reviewed NEWS2 records for three patients and saw they had been escalated and repeated in line with trust policy. Ward sisters monitored completion of NEWS2 and other risk assessments electronically. Matrons monitored compliance with NEWS2 calculation and escalation of the deteriorating patient as part of their monthly audits. The information system displayed the patients, when assessments and observations had been completed and when they were due. Ward sisters monitored this regularly and ensured staff carried out observations using NEWS2.

Staff knew about and dealt with some specific risk issues. All patients were screened for methicillin resistant staphylococcus within 48 hours of admission. Staffed logged this in the electronic patient record and the infection prevention and control team monitored patients screened as positive weekly. The screening process was repeated every 30 days with a reminder on the electronic patient record.

Senior nurses reviewed all occurrences of hospital acquired pressure ulcers at the weekly harms panel meeting. Every patient fall was also reviewed at the harms panel including those with no harm and an investigation. Staff carried out an investigation following any patient fall.
Staff could access support to prevent patient falls from a lead nurse and consultant for falls. The service used red clipper socks to indicate patients who were at risk of falling and placed sensor beds around the bed. Staff managed patients at risk of falling through cohort bays and bay tagging. Bay tagging is where nursing staff tag someone else on to the bay if they need to leave ensuring there is someone present in the bay at all times, as far as possible.

At the time of our inspection the observational policy for patients at risk of falls was under review. The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). We reviewed notes for four patients who had been referred for support from the team. We found mental health assessments and risk assessments in all notes. Patients had been given safety plans and mental health care plan was in place. The diagnosis was recorded in the electronic patient record system and flag placed on the record so staff could easily identify patients in need of mental health support.

Shift changes and handovers included all necessary key information to keep patients safe. We observed a handover on the older persons assessment ward and saw nurses kept written handover notes. There was a safety huddle on the ward prior to handovers where any important information was shared between the whole team.

**Nurse staffing**

The service generally had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, fill rates for allied health professional staff were low.

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service generally had enough nursing and support staff to keep patients safe. However, ward 25, medical short stay ward and the older persons assessment unit had lower numbers than expected of registered nursing staff on shift in September 2019. We reviewed published fill rates for nursing staff in September 2019. The fill rates for day and night for registered and non-registered nursing staff and allied health professionals for day and night were published as below:
During our inspection we saw staffing boards at entrances to ward displayed actual versus planned staffing each day. They showed planned staffing levels being reached.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, not all escalation areas had dedicated staffing allocated and this led to high bank use and staff moves.

Managers told us they would be piloting the safe care staffing acuity tool in acute medicine in November 2019. Managers attended a daily staffing meeting at 10am as part of the divisional safety huddle. Staffing levels for that day, the previous 24-hours and next 24-hours were reviewed and adjusted at that meeting.

Nursing staff told us they were often moved during or at the beginning of their shift to cover other areas, not only medical care wards. The service did not have a system to track and monitor staff moves.

The urgent medical assessment unit, formerly ambulatory care did not have a substantive nursing establishment allocated. Leaders told us that a business case had been approved to staff the ward, but this was not in place at the time of our inspection. We saw that the urgent medical assessment unit was open at night during our inspection as a five bedded bay. This meant staff were moved from the acute medical unit meaning the ratio of registered nurses to patients on the unit was 1:8 not the planned 1:7.

The reverse cohort area in the emergency department was not substantively staffed. Managers and staff told us this area was sometimes used overnight for medical patients and when this happened nursing and support staff were moved from medical care wards to staff the area.

During our inspection ward one, surgical day case unit, was open as a 21-bed medical care escalation ward. This was staffed Monday to Friday 8am to 8pm by surgical nursing staff. Outside of these hours the ward used bank nursing staff. Nurses we spoke with told us they were often asked to move to ward one at night to provide cover.

**Arrowe Park Hospital**

The table below shows a summary of the nursing staffing metrics in medicine at Arrowe Park Hospital compared to the trust's targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>0%</td>
<td>8%</td>
<td>10%</td>
<td>4.0%</td>
<td>43,227 (6%)</td>
<td>4,097 (1%)</td>
<td>64,475 (9%)</td>
</tr>
<tr>
<td>All staff</td>
<td>1,615.4</td>
<td>8%</td>
<td>10%</td>
<td>4.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>607.5</td>
<td>14%</td>
<td>9%</td>
<td>4.1%</td>
<td>43,227 (6%)</td>
<td>4,097 (1%)</td>
<td>64,475 (9%)</td>
</tr>
</tbody>
</table>

The trust provided a 0% vacancy target. Following our inspection, we asked the service to clarify the vacancy target and they told us the trust turnover target was 10%. They provided information that showed the vacancy rate for nursing and midwifery staff in medicine and acute division was 10.75%.
We could not be assured that staffing rates figures for Arrowe Park Hospital were accurate as staff were not mapped consistently to sites by the trust in information we received prior to the inspection.

Nurse staffing rates within medicine were analysed for the past 12 months and indications of improvement, deterioration or change were identified in monthly rates for sickness, turnover and bank use.

**Vacancy rate**

The service had static vacancy rates.

![Vacancy rate - qualified nurses, health visitors and midwives](image)

However, monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from October 2018 to February 2019. This could be an early indicator of deterioration.

The service had taken a number of actions to recruit nursing staff. They had a rolling recruitment drive including speciality recruitment days which worked well to attract new staff. The service had recently recruited 40 newly qualified nurses who would start in March 2020 after they completed nurse training.

From November 2019, matrons were introducing holding ‘itchy feet’ clinics for staff thinking of leaving. This was aimed to improve retention of nursing staff and would give staff the opportunity to chat through options and career development opportunities. The service had also planned a six-monthly careers event for staff to try and improve retention.

The service had recently reviewed the required nurse staffing levels for the respiratory ward which had led in an increase in nursing establishment. At the time of our inspection the service had recruited but staff were not yet in post.

**Agency staff usage**

The service had reducing rates of agency nurses used on the wards.
Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from August 2018 to January 2019. While agency use subsequently declined in the period Feb to April 2019.

The ward manager could adjust staffing levels daily according to the needs of patients. However, managers told us that requests for additional staff to meet the acuity of patients and those requiring one to one care were often refused. Matrons made decisions on nursing staff moves between wards on a day by day basis. They changed the electronic roster in line with nursing staff moves.

Managers told us they used NHS professionals (NHSP) bank nursing staff rather than agency staff as this meant they could use their own staff who were familiar with the ward areas.

However, managers also told us staff from NHSP often cancelled at last minute and it was difficult for them to take action to avoid this or raise this with staff.

Managers made sure all bank and agency staff had a full induction and understood the service.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Patients we spoke with confirmed they had been reviewed by a doctor every day.

However, we found that not all patients who were medical outliers were reviewed by a doctor at weekends. Ward 25 did not have dedicated doctors as all patients were considered medical outliers as they were placed there for infection control purposes. This was an issue we highlighted during our last inspection. During the week patients were seen daily by the post take ward round doctor. Managers told us it could be difficult to get a review by a doctor at weekends and out of hours. There was a clear process in place on the ward for escalation to and review by a doctor.

**Arrowe Park Hospital**

The medical staff matched the planned number. The service had a team of advanced nurse practitioners who were included within the medical rota. Advanced nurse practitioners are registered nurses who have done additional training and are able to treat, diagnose and prescribe medication.

The table below shows a summary of the medical staffing metrics in medicine at trust level compared to the trust’s targets, where applicable:
<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>1,615.4</td>
<td>8%</td>
<td>10%</td>
<td>4.0%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical staff</td>
<td>203.3</td>
<td>12%</td>
<td>13%</td>
<td>0.6%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The trust provided a 0% vacancy target. Following our inspection, we asked the service to clarify the vacancy target and they told us the trust turnover target was 10%. They provided information that showed the vacancy rate for medical staff in medicine and acute division was 10.57%.

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

We could not be assured that staffing rates figures for Arrowe Park Hospital were accurate as staff were not mapped consistently to sites by the trust in information we received prior to the inspection.

Medical staffing rates within medical care at the trust were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly turnover, sickness, bank and agency usage rates.

Vacancy rates

The service had increasing vacancy rates for medical staff.

![Vacancy rate - medical staff](image)

Monthly vacancy rates over the last 12 months for medical staff shows a shift from December 2018 to May 2019. This could be an indicator of change.

Senior managers told us medical staffing remained a challenge in some areas particularly haematology. However, they were able to fill gaps through locum doctors who stayed long term. The service had plans to recruit shared speciality consultants to fill gaps in hard to recruit to specialities.

The service had recently appointed medical staff for diabetes, cardiology, rheumatology and acute medicine. However, two out of eight cardiology consultants were locums.

The service had plans in place to recruit substantive medical staff for the medical short stay ward and ward 33. At the time of our inspection these were staffed by locum doctors.

Staffing skill mix
In March 2019, the proportion of consultant staff and middle career staff reported to be working at the trust were about the same as the England averages and the proportion of junior (foundation year 1-2) staff was higher than the England average. The proportion of the registrar group staff was lower than the England average.

**Staffing skill mix for the 146 whole time equivalent staff working in medicine at Wirral University Teaching Hospital NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>48%</td>
<td>45%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>17%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>28%</td>
<td>20%</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 (March 2019))

However, doctors we spoke with told us the skill mix in their areas was not right. Consultants reported they were often on call with inexperienced doctors and it was difficult to recruit senior doctors. They felt senior doctors often covered tasks that could be done by junior doctors.

On the haematology day ward there was sometimes only one advanced nurse practitioner on rota. Staff told us that if they were on with a nurse who was not a non-medical prescriber this caused difficulties getting medicines for patients in a timely way.

The service always had a consultant on call during evenings and weekends. On call arrangements for senior doctors meant that speciality consultants covered all medical care areas. Cardiology consultants did not. Consultants told us this meant they sometimes were pulled away from their specialist areas to answer on call bleeps.

**Records**

**Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, records were not always stored securely.**

We viewed 15 patient care records and saw they were legible, clear and all dated and signed. Patient notes were comprehensive, and all staff could access them easily through the electronic patient record system or end of bed paper-based nursing records.

However, we found it was not easy to find care plans based on completed risk assessments within the electronic patient record. Care plans were not individualised to patients as there was no facility to add free text, only drop-down boxes to choose from.

Compliance with standards of some documentation was checked through matron and perfect ward audits. However, this did not include all elements of nursing notes, including all risk assessments.
and care plans. We reviewed the questions asked during audit about documentation and saw these only included observation completion, ‘this is me’ passports, medicines administration records, fluid balance charts and venous thromboembolism risk assessments.

Records were not stored securely in all areas. Since our last inspection the service had introduced new lockable records trolleys. However, we found trolleys left unlocked on ward 23, the urgent medical assessment unit, medical short stay ward, acute medical unit and older peoples assessment unit. On medical short stay ward, we saw a computer terminal left open with patient names and details on display on two occasions. We escalated this to the matron who corrected this during the inspection.

**Medicines**

**Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.**

The trust had an established electronic prescribing and administration system that staff used competently. Alerts on the system meant that staff could prioritise patients and ensure medicines were given at the right time. We reviewed 82 electronic prescription charts and found no areas of concern regarding the prescribing and administering of medicines. Patients had their medicines thromboembolism (VTE) risk assessments completed and appropriately recorded.

Antimicrobial treatments were prescribed and reviewed appropriately, and antimicrobial stewardship information was available for each patient including indication and allergy status. Medicines reconciliation was carried out for all of the patient’s records we checked.

We looked at medicine audits which demonstrated wards were compliant with safe storage of medicines, though we found some issues on the acute medical unit. We checked medicines storage on four wards and found stock was stored correctly and in date. We reviewed monthly medicines storage audits conducted by matrons and saw that compliance was above 95% from April 2019 to our inspection date.

Work had been undertaken to improve the storage and documentation of controlled drugs since the last inspection and results demonstrated this. Controlled drugs were robustly monitored by pharmacy and we reviewed weekly and quarterly controlled drugs audits. Theses demonstrated in June 2019 that compliance with appropriate storage and documentation of controlled drugs was 94% across the service. We reviewed the controlled drug register on two wards and found it was fully and correctly completed.

Medicines housekeepers were responsible for managing medicines storage, including patients own and helping patients transfer between locations and recycling medicine waste. Discharge prescriptions were processed quickly by ward-based pharmacists and technicians in satellite dispensaries and staff based in the discharge lounge ensured patients received advice about their medicines before they went home.

Staff received updates on medicines safety alerts and incidents form the medicines safety officer team. Staff could access daily medicines safety drop in session which included a review and debrief of medicines incidents and ensuring staff knew how to report medicines incidents. The medicines safety officer also sent ‘quick fire’ email messages to junior doctors to highlight any lessons learnt or medicines safety alerts.
Patients we spoke with told us they had the opportunity to speak to pharmacy staff about their medicines.

Staff checked ambient room and medicine fridge temperatures daily. All records we checked showed maximum and minimum temperatures were checked and within range. We saw staff acted when temperatures fell outside acceptable ranges. However, on medical short stay ward we found ambient room temperatures outside acceptable ranges had not been escalated.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff we spoke with told us they were encouraged to report incidents and could give examples of the type of incidents they would report.

Staff raised concerns and reported incidents and near misses in line with trust policy. Ward sisters reviewed all incidents submitted and shared the outcomes and any learning in safety huddles and the monthly staff newsletter. An email with feedback from incidents reported was automatically sent to the member of staff reporting the incident through the electronic reporting system.

Never Events

The service had one never event on medical short stay ward between July 2018 and June 2019. 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 July 2018 to June 2019, the trust reported one never event for medicine. This was for a misplaced naso- or oro-gastric tube at Arrowe Park Hospital in June 2018.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning about never events with their staff and across the trust. The service told us that following the never event they had introduced new nurse competencies for aseptic non-touch technique and naso-gastric tube care. Practice educator facilitators delivered on-the-job training to these competencies to nurses. All naso-gastric tube patients were now discussed in the daily safety huddle across the service.

Breakdown of serious incidents reported to STEIS

Arrowe Park Hospital

In accordance with the Serious Incident Framework 2015, the trust reported 17 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from July 2018 to June 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls</td>
<td>6</td>
<td>35.3%</td>
</tr>
<tr>
<td>Diagnostic incident including delay (including failure to act on test results)</td>
<td>3</td>
<td>17.7%</td>
</tr>
<tr>
<td>HCAI/Infection control incident</td>
<td>3</td>
<td>17.7%</td>
</tr>
</tbody>
</table>
Surgical/invasive procedure incident | 2 | 11.8%
Medication incident | 2 | 11.8%
Pending review (a category must be selected before incident is closed) | 1 | 5.9%
Total | 17 | 100.0%

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. All staff we spoke with were aware of the term and the principle behind the regulation and could give examples of when the duty of candour would be applied.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received a weekly bulletin following the harms panel meeting with lesson learnt highlighted. This was sent by email and to every ward.

There was evidence that changes had been made as a result of feedback. For example, the service had worked with the estates department to do a check of all bathrooms following a number of falls happening in bathrooms and toilets. The check looked at any environmental factors that could contribute to falls and ensured any corrective work was carried out.

Staff met to discuss the feedback and look at improvements to patient care. The service held a weekly harms panel meeting to look at incidents related to falls and pressure ulcers. However, we observed a harms panel meeting and saw there was no multi-disciplinary team involvement as doctors and therapy staff did not attend. In the meeting, we observed there was no learning identified from either incident.

Safety thermometer

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

Safety thermometer data was displayed on wards for staff and patients to see. The data was also shared with staff at the monthly staff meeting. However, we saw results were not displayed on ward 21 and staff told us the data had not been made available to them.

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.

The safety thermometer data showed the service achieved harm free care within the reporting period. In August 2019, the harm free care score was 95%.

Staff used the safety thermometer data to further improve services. The service had introduced changes to reduce the number of falls. It had removed nurse stations, so staff had to sit in bays to complete nursing notes. This meant improved observation of patients at risk of falls.

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 56 new pressure ulcers, 49 falls with harm and 52 new urinary tract infections in patients with a catheter from May 2018 to
May 2019 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Wirral University Teaching Hospital NHS Foundation Trust

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

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service generally provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. New falls risk assessments and a falls bundle had been developed using National Institute of Health and Care Excellence (NICE) guidance. A bundle is a set of interventions that, when used together, significantly improve patient outcomes.

The service managed sepsis through the sepsis six pathway in line with NICE guidance.

We observed at handover meetings staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

In line with best practice, ward staff were supported to care for patients with presenting mental health conditions through the provision of the mental health liaison team. This service was provided by a nearby mental health trust. The mental health liaison team were available seven days a week, 24 hours a day.
However, staff told us the service was struggling to meet national guidelines for timeframes for carrying out echocardiograms as time slots for performing the test only lasted 20 minutes. British Society of Echocardiography guidance in 2018 recommended the average time required for performance and reporting of a fully comprehensive echocardiogram was 40 to 45 minutes. An echocardiogram (echo) is a graphic outline of the heart's movement which doctors use to check for problems with the valves or chambers of the heart.

The respiratory ward did not have a level two ventilation unit. British Thoracic Society guideline for patients with acute respiratory failure receiving non-invasive ventilation state they should be treated in a specifically identified area at level two equivalence.

**Nutrition and hydration**

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients could choose from a variety of food options that were cooked in the on-site restaurant and delivered to the wards on heated trolleys. Patients told us staff would go out of their way to get them an alternative if they did not like the food.

Each ward had a nutritional status boards completed. This showed the dietary requirements of each patient including any special instructions such as soft or puree food and if the patient was diabetic. The board was updated by the ward housekeeper who also went through the menus with patients and helped them make choices. Menus catered for patient with specific dietary requirements such as gluten free or low sugar.

The service had protected meal times on wards. These were set time periods on the ward when all non-urgent clinical activity was stopped. This ensured patients could eat without being interrupted and staff were available to offer help with eating and drinking. However, we observed staff carrying out a medicine round during meal time on one ward.

On each ward a member of staff was allocated as a meal time coordinator. They ensured all patients were prepared for meal times by helping them to the bathroom, to sit in a chair or on the bed and encouraging hand hygiene.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Since our last inspection the service had improved compliance with nutritional screening using the Malnutrition Universal Screening Tool (MUST). We saw evidence that MUST compliance the week prior to inspection was 99.5%. Compliance with MUST screening was monitored by matrons through an electronic patient record audit system. This system meant ward sisters and matrons could see when a MUST screen was due for each patient and follow this up with staff.

Patients who needed support to eat or drink were given food on red trays. This meant that staff could readily identify patients who needed additional assistance to eat and drink. Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it.

Patients, carers and staff could access a café and restaurant on site.

Staff did not always fully and accurately complete patients’ fluid and nutrition charts. We reviewed food records for three patients and saw nothing was recorded on their food chart. Staff told us they completed food and fluid charts on paper and inputted these at end of their shift. This meant that
sometimes staff did not record fluid and nutritional balance or there was a risk errors could occur in transferring the record from paper to computer.

Patients we spoke with told us there was lots of choice of food. However, some patients told us the food was not enjoyable and often served cold. Patients received their main meal and pudding together. This meant that patients who were confused may mix their main and pudding together and also warm puddings were cold by the time patients had opportunity to eat them.

**Pain relief**

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

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff assessed patients’ pain during observations and ‘rounding’ using a pain chart and scoring system. Patient ‘rounding’ is a process of regular nursing checks to ensure patient’s fundamental care needs are being met.

Patients received pain relief soon after requesting it. Pain relief was available and patients we spoke with told us they had received pain relief in a timely manner.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements. The service had been accredited under relevant clinical accreditation schemes. However, outcomes for patients were not always positive, consistent and did not meet all expectations and national standards.

The service did not participate in all relevant national clinical audits. For example, they did not participate in the 2017 National Diabetes Inpatient Audit.

The service did not meet required standards in all areas in some national audits and some services had higher than expected risks of readmission. For example, the service did not meet the standard for patients being seen by a cancer nurse specialist in the 2018 National Lung Cancer Audit. It did not meet the required standard in any key indicator in the 2017 National Audit of Inpatient Falls.

Managers and staff used the results to improve patients' outcomes.

**Relative risk of readmission**

**Trust level**

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

**Elective admissions – Trust level**

- Patients in gastroenterology and respiratory medicine had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity.

Non-elective admissions – Trust level

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine and respiratory medicine had a similar to expected risk of readmission for non-elective admissions

Arrowe Park Hospital

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

Elective admissions - Arrowe Park Hospital

- Patients in gastroenterology and respiratory medicine had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions

The service had a similar to expected risk of readmission for elective care than the England average.

Non-elective admissions - Arrowe Park Hospital
Patients in general medicine had a lower than expected risk of readmission for non-elective admissions.

Patients in geriatric medicine and respiratory medicine had a similar to expected risk of readmission for non-elective admissions.

The service had a lower than expected risk of readmission for non-elective care than the England average.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

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

Arrowe Park Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest audit, January to March 2019, which was the same as the previous audit.

**Arrowe Park Hospital**

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
<th>Jan 19 - Mar 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
</tr>
<tr>
<td>Case ascertainment band</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>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
</tr>
</tbody>
</table>

**Patient centred performance**

<table>
<thead>
<tr>
<th>Domain 1: Scanning</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
<th>Jan 19 - Mar 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C↓</td>
<td>C↑</td>
<td>D↓</td>
<td>D</td>
</tr>
</tbody>
</table>

- Domain 3: Thrombolysis has seen a deterioration in patient and team centred performances in the latest audit (level C) compared to the previous audit (level B).
- Domain 5: Occupational therapy has seen an improvement in both patient and team centred performance in the latest audit (level A) compared to the previous audit (level B).
- All other metrics have shown no change in patient and team performance compared to the previous audit.
- Domain 2: Stroke unit scored poorly in patient centred performance and team centred performance in the latest two audits (level D).
- Domain 7: Speech and language therapy scored poorly in patient centred performance and team centred performance in the latest four audits (level E).
The service performed poorly in the speech and language therapy domain for both team centred and patient centred performance. Leaders confirmed there was no action plan in place to address this as the overall score remained good. The service had access to speech and language therapy five days a week through 1.5 whole time equivalent staff providing approximately 18-hour input per patient. Staff told us at weekends there was one speech and language therapist for the whole hospital. At the time of our inspection staff told us 46% of the patients on the stroke unit required input from speech and language therapy.

**National Diabetes Inpatient Audit**

Wirral University Teaching Hospital NHS Foundation Trust did not participate in the 2017 National Diabetes Inpatient Audit.

*Source: National Diabetes Audit 2017*

**Lung Cancer Audit**

The table below summarises Wirral University Teaching Hospital NHS Foundation Trust’s performance in the 2018 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist</td>
<td>87.0%</td>
<td>Does not meet the audit aspirational standard</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Case-mix adjusted one-year survival rate</td>
<td>39.6%</td>
<td>Within expected</td>
<td>No current</td>
</tr>
<tr>
<td>Metrics (Audit measures)</td>
<td>Trust performance</td>
<td>Comparison to other Trusts</td>
<td>Met national standard?</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>-----------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>(Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Case-mix adjusted percentage of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery</strong> (Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td>16.2%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment</strong> (For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>74.1%</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy</strong> (SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>81.8%</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
</tbody>
</table>

(Source: National Lung Cancer Audit 2018)

**National Audit of Inpatient Falls**

**Arrowe Park Hospital**

The table below summarises Arrowe Park Hospital’s performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit's Rating</th>
<th>Met national aspirational standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?</td>
<td>No</td>
<td>N/A</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients who had a vision assessment (if applicable) (Having a vision assessment is indicative of good practice in falls prevention)</td>
<td>0.0%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) (Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention)</td>
<td>37.9%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients assessed for the presence or absence of delirium (if applicable) (Having an assessment for delirium is indicative of</td>
<td>13.8%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
Managers used information from the audits to improve care and treatment. The service had acted to reduce the number of inpatient falls since our last inspection. The lead nurse for dementia also acted as the falls lead. The service now had a falls care bundle for staff to follow and all falls were reviewed at the weekly harms panel. The service was developing a post fall care bundle at the time of our inspection.

**Chronic Obstructive Pulmonary Disease Audit**

**Arrowe Park Hospital**

The table below summarises Arrowe Park Hospital’s performance in the 2018/19 Chronic Obstructive Pulmonary Disease Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients seen by a member of the respiratory team within 24hrs of admission? (Specialist input improves processes and outcomes for COPD patients)</td>
<td>87.6%</td>
<td>Better than the national aggregate</td>
<td>Met</td>
</tr>
<tr>
<td>Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) (Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)</td>
<td>100%</td>
<td>Better than the national aggregate</td>
<td>Met</td>
</tr>
<tr>
<td>Percentage of patients receiving non-invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival (NIV is an evidence-based intervention that halves the mortality if applied early in the admission)</td>
<td>Not available</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy (Smoking cessation is one of the few interventions that can alter the trajectory of COPD)</td>
<td>85.6%</td>
<td>Better than the national aggregate</td>
<td>Met</td>
</tr>
<tr>
<td>Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission (Completion of a discharge bundle improves readmission rates and integration of care)</td>
<td>83.6%</td>
<td>Better than the national aggregate</td>
<td>Met</td>
</tr>
<tr>
<td>Percentage of patients with spirometry confirming FEV1/FVC ratio &lt;0.7 recorded in case file (A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt)</td>
<td>68.4%</td>
<td>Better than the national aggregate</td>
<td>Met</td>
</tr>
</tbody>
</table>
### National Audit of Dementia

**Arrowe Park Hospital**

The table below summarises Arrowe Park Hospital’s performance in the 2017 National Audit of Dementia.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good <em>(A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</em></td>
<td>68.6%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of staff responding “always” or “most of the time” to the question “Is your ward/ service able to respond to the needs of people with dementia as they arise?” <em>(This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)</em></td>
<td>81.1%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium <em>(Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</em></td>
<td>10.0%</td>
<td>Worse</td>
<td>No current standard</td>
</tr>
<tr>
<td>Multi-disciplinary team involvement in discussion of discharge <em>(Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)</em></td>
<td>91.4%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

*(Source: National Audit of Dementia 2017)*

Managers shared and made sure staff understood information from the audits. Improvement was checked and monitored. Matrons and associate directors of nursing carried out a ‘perfect ward’ audit programme. This included ensuring improvement plans were in place for issues identified in matron audits and the top five repeat poor performance areas for the division were reviewed and an improvement plan in place.

The service was accredited by Joint Advisory Group on Gastro-intestinal Endoscopy (JAG).

### Competent staff

The service made sure the majority of staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.
Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. However, some staff groups told us it was difficult to access appropriate training for their role.

Managers gave all new staff a full induction tailored to their role before they started work.

**Appraisal rates**

**Trust level**

From April 2018 to March 2019, 88.3% of staff within medicine department at the trust received an appraisal compared to a trust target of 88%.

A breakdown of appraisal completion rates by staff group is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>19</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>6</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>115</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>165</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>393</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>455</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>148</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>1</td>
</tr>
</tbody>
</table>

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with told us they felt their appraisal was useful and helped them to identify their development needs. However, in the information the trust provided before our inspection, staff were not mapped consistently to sites. This meant we cannot be assured the appraisal figures were accurate.

**Arrowe Park Hospital**

From April 2018 to March 2019, 87.7% of staff within medicine department at the trust received an appraisal compared to a trust target of 88%.

A breakdown of appraisal completion rates by staff group is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>18</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>6</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>105</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>164</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>348</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>413</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>120</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>1</td>
</tr>
</tbody>
</table>
Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us they got good quality, regular clinical supervision.

The clinical educators supported the learning and development needs of staff. The service had recently provided aseptic non-touch technique training to staff through newly appointed practice educator facilitators. The infection prevention and control team provided specialist training in infection prevention and control as part of the new starter, newly qualified nurse and clinical support worker programmes.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Each ward had a monthly team meeting and notes were shared with staff by email. There was also a hard copy of meeting notes available on each ward.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Medical staff received three hours per week protected time for training and learning. Staff we spoke to told us they did get this protected time.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us they got good support from the human resources department to tackle any performance issues and support staff to improve or act when performance did not improve.

However, managers did not make sure all staff received any specialist training for their role. Therapy and advanced nurse practitioner staff we spoke with told us access to appropriate training opportunities was limited. Staff also told us it was difficult to get training in specialist areas such as cardiology and that training provided did not always meet the needs of newly qualified staff.

Staff gave the example of difficulty accessing tracheostomy training. They explained this meant there were sometimes delays in patients receiving tracheostomy care or changes as there might not be a suitably trained member of staff on shift. The service told us that ward 38 had staff with appropriate levels of competency and patients requiring tracheostomy care were cohorted to this ward. At the time of our inspection 30% of registered nurses on ward 38 had completed an enhanced tracheostomy care training package.

**Multidisciplinary working**

*Doctors, nurses and other healthcare professionals did not consistently work together as a team to benefit patients.*

Staff did not always work effectively across health care disciplines and with other agencies when required to care for patients. We reviewed six patient notes and saw though discussion across health disciplines was recorded there were no specific goals set for patients and no evidence for combined personalised goals. We saw no evidence of psychology input into the multidisciplinary team.

Some therapy staff told us there was limited joint working with nursing staff and they did not work together to set multidisciplinary team goals for patients. We did not see evidence that therapy staff were involved in audits on the wards other than the national Sentinel Stroke National Audit programme.

Some patients we spoke with reported difficulties receiving timely care and treatment when different teams were involved in their care. They told us they had experienced delays when their care needed to be transferred to other providers or hospitals.

Not all patients had their care pathway reviewed by relevant consultants. Patients on ward 25 were considered ‘outliers’ as they were placed on the ward for infection control purposes. The ward did
not have dedicated medical cover. This meant patients care was reviewed by the post take doctor not the relevant consultant from the ward they were transferred from. We highlighted this to the trust at our last inspection. We told them they should ensure that patients accommodated on escalation wards have access to a dedicated multidisciplinary team and all patients who were not on the correct speciality ward, had regular senior medical reviews.

However, staff on the stroke unit told us they could access good specialist support for patients from tissue viability nurses, the infection prevention and control team and the intravenous team. They told us nursing staff had positive, respectful working relationships with consultants.

Nursing staff on some wards told us they had excellent working relationships with doctors and advanced nurse practitioners.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed a multidisciplinary team board round on one ward and saw all relevant professional attended including doctors therapy staff and social workers. Every patient was discussed We saw staff identified actions that had not been carried out and identified patients for discharge. We saw all staff were encouraged to speak up and provide input to the meeting.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. We reviewed records for four patients who were referred for mental health support and saw they had a relevant mental health assessment and care plan completed.

Seven-day services

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

Consultants led daily ward rounds, including weekends on most wards. However, not all patients cared for on a ward which was not their speciality were reviewed by a consultant or doctor at the weekend. Managers acknowledged that the daily consultant led board round lacked a clear structure could be improved.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There was 24 hour a day on call consultant cover.

Some therapy services were available for patients seven days a week. However, speech and language therapy services were only available five days a week..

Health promotion

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

Staff provided support for any individual needs to live a healthier lifestyle. Staff could refer patients on the respiratory wards directly to smoking cessation services to help them give up smoking.

Staff assessed each patient’s health when admitted. The patient risk assessment documents included health promotion questions on alcohol intake and smoking. They included a prompt to refer patients to relevant support teams.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, staff were not aware of a system for tracking and monitoring deprivation of liberty safeguards applications and when they expired.
Staff we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care. However, managers told us mental capacity assessments and best interest decisions tended to be completed by ward sisters as staff did not have time.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. ‘Do not attempt cardio-pulmonary resuscitation’ (DNACPR) records we reviewed were all correctly completed. However, we found one patient who had an emergency health care plan, as well as an DNACPR and this had not been correctly completed as it was not signed by a doctor.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients’ records. We reviewed the consent audit for 2018 to 2019 in endoscopy. We saw the service audited 93 patient consent records and the consent form was completed in 97.8% and of these 100% had been signed by the patient and the clinician. 100% of the forms detailed the intended benefits of the treatment and 98.9% detailed the risks.

**Mental Capacity Act and Deprivation of Liberty Safeguards training completion**

Some staff received and kept up-to-date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Some staff groups, such as allied health professionals, told us they did not receive Mental Capacity Act and Deprivation of Liberty Safeguards training.

The trust did not provide any data for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

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

Following our inspection, the service provided told us that this training is included in all levels of the protecting vulnerable people training. Compliance with this training for nursing staff was 93.1% with level two training and 87.6% with level training. The service told us the safeguarding team provide bespoke training to ward staff during walk rounds and when requested by staff or a ward.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Staff were supported and prompted by the trust safeguarding team to submit DoLS applications and carry out mental capacity assessments.

The safeguarding team monitored the use of Deprivation of Liberty Safeguards and mental capacity assessments. However, staff we spoke with told us they were not offered support to complete these and were not asked if they knew how to complete them. We saw these were not monitored through matron or associate director of nursing audits, as part of perfect ward audits. However, the matron audit included one question for staff on who could complete a capacity assessment.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. However, as the safeguarding team were responsible for tracking and monitoring capacity assessment and DoLS documentation staff were not always aware if a DoLS authorisation had expired. This meant there was a risk ward staff could unlawfully deprive a patient of their liberty if the authorisation had expired and they were not aware. Managers we spoke with were unclear on process to track and audit DoLS expiry. They told us the safeguarding team were responsible for follow up when an urgent application expired and they were not informed of the outcome. Managers stated they had raised this with the safeguarding team.

Following our inspection, the service told us for every seven-day urgent application submitted the safeguarding team also requested an extension to ensure the authorisations do not expire. They provided information that showed they submitted 356 DoLS applications between August and October 2019. Of these 341 required an extension and 27 had an extension expiry date recorded.
We reviewed records for three patients who were subject to DoLS. In all records we saw the capacity assessment, DoLS application and best interest decision paperwork was correctly completed. However, we saw in one record the urgent DoLS application had expired four days earlier. There were no updates on the patient record regarding the standard authorisation and staff were not aware if the authorisation had been made and were still applying the deprivation of liberty.

Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update. Since our last inspection the service had introduced a new system to improve the timely sending and monitoring of DoLS applications.

Is the service caring?

Compassionate care

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

We spoke to patients on the wards and observed care and treatment in all areas. Patients we spoke with said staff treated them well and with kindness. Comments such as ‘staff are amazing’, ‘they go out of their way to help’ and ‘they are always happy’ were received.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients and visitors told us staff always introduced themselves. Patients told us staff were responsive, even though they were busy, one patient told us ‘they are busy, but they always take time to talk’.

Staff followed policy to keep patient care and treatment confidential. Patients confirmed that they drew curtains round the bed space when providing care and treatment to protect the patient’s privacy and dignity.

However, during our observation of care on the medical short stay ward we saw staff did not always introduce themselves to patients before providing care and treatment. The environment in the discharge lounge did not keep patient care and treatment confidential as the discharge to assess team had their desk in the trolley area.

Some patients told us that though staff treated them well, the ward was busy, and this led to delays in care being provided. An example was given of seeing another patient in distress and staff were slow to attend.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We carried out a group observation using the Short Observational Framework for Inspection (SOFI) method on 15 October 2019. The SOFI tool is used to review services for people who have conditions that mean they cannot reliably give their verbal opinions on the services they receive. We continually observed what happened to patients over a chosen observation period, making recordings at set intervals. In each time period, we recorded the general mood of the service users, the type of activity or non-activity they were engaged with and the style and number of staff interactions with service users. In each time frame there may be more than one type of engagement and multiple interactions with staff. Interactions with staff are categorised as positive, neutral or poor.

The group observation took place in a male five bedded bay at a meal time. The observation
started at 12:00 pm and lasted 45 minutes. We observed five patients and two members of staff and one volunteer. Data was collected in 5-minute time frames.

- The general mood state for patients throughout the observation was neutral for 85% of the period, 11% of the time it was positive and 4% of the time it was negative.
- In 48% of the time frames the patients were engaged with a task such as eating their meal. In 65% of the time frames there was engagement between patients and staff or visitors.
- There was some interaction with staff in 52% of the time frame. 64% of staff interactions were neutral, 36% were positive and none were poor.

Throughout the observation we saw staff engage with patients in a warm, friendly yet respectful way. We saw staff acting promptly to support a patient experiencing pain and providing support to a patient to eat their meal. We saw staff gently trying to wake a patient to ensure he got his hot meal and offering an alternative to the hot meal.

**Emotional support**

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We spoke to two relatives of a patient cared for in a side room as they were on an end of life pathway. They told us staff had discussed counselling and bereavement support services and had signposted them to relevant agencies. The palliative care team provided in reach services into the ward to ensure patients and relatives received appropriate help, support and advice.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Relatives of an end of life patient told us staff were ‘fantastic’ and looked after their needs as well as the patients.

One patient told us staff had been very supportive when they became distressed. They told us staff had sat with them and put their arm around them to provide reassurance.

Volunteers provided emotional support and listening services on the dementia wards. They also assisted patients at meal times. We spoke to a volunteer who explained some volunteers had completed additional training to provide emotional support to patients at the end of life.

The service used a butterfly symbol to indicate where patients were being cared for at the end of their life. This ensured all staff and visitors were aware of this and could respond appropriately to patients and visitors in those areas.

**Understanding and involvement of patients and those close to them**

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

Staff made sure patients and those close to them understood their care and treatment. We saw evidence in patient records of discussion with family and carers about the patients’ care and treatment. Patients we spoke with told us staff took time to explain their care and treatment to them.

Staff talked with patients, families and carers in a way they could understand. Relatives, visitors and patients we spoke with told us they had never been talked over and staff were good at explaining things in simple terms. Two relatives of an end of life patient told us all staff had been very respectful and all clinicians held respectful yet honest conversations with them.
The service was registered with John’s Campaign. John’s Campaign states that in hospitals carers of dementia patients should not just be allowed but should be welcomed, and that collaboration between patients and all connected with them is crucial to their health and their well-being. The service provided reclining chairs for carers to stay with patients. The wards had open visiting hours for relatives and carers.

**Friends and Family test performance**

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw poster displaying Friends and Family Test results and encouraging patients to respond on the wards.

From June 2018 to May 2019, the Friends and Family Test response rate for medicine at the trust was 19%, which was lower than the England average of 24%.

The table below shows the response rate by site:

<table>
<thead>
<tr>
<th>Location/site</th>
<th>Number of responses</th>
<th>Response rate</th>
<th>Annual performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrows Park Hospital</td>
<td>2,810</td>
<td>18%</td>
<td>98%</td>
</tr>
<tr>
<td>Clatterbridge Hospital</td>
<td>208</td>
<td>62%</td>
<td>90%</td>
</tr>
<tr>
<td>Total</td>
<td>3,018</td>
<td>19%</td>
<td>97%</td>
</tr>
</tbody>
</table>

The table below shows both the response rate by ward and the percentage of patients on those wards that would recommend the service to friends or family:

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total responses</th>
<th>Resp. Rate</th>
<th>Percentage recommended¹</th>
<th>Annual perf²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Responder Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENDOSSC</td>
<td>808</td>
<td>11%</td>
<td>99%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 38</td>
<td>272</td>
<td>45%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 23</td>
<td>158</td>
<td>35%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>EDRU</td>
<td>145</td>
<td>35%</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>ACU</td>
<td>145</td>
<td>22%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 37</td>
<td>129</td>
<td>48%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 22</td>
<td>119</td>
<td>35%</td>
<td>100%</td>
<td>93%</td>
</tr>
<tr>
<td>Ward 30</td>
<td>106</td>
<td>51%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 2</td>
<td>105</td>
<td>29%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Key**

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), as well as wards where there were less than 100 responses in total over the 12 month period.
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.

From June 2018 to May 2019:

- Annual performance for all wards was between 88%-100%
- Endoscopy had the lowest response rate (11%), which it accounted for 26.8% of all responses across the medical wards.
- Ward M1 (rehabilitation) had the highest response rate (51%), which it accounted for 3.5% of all responses across the medical wards.
- Ward 23 (geriatric medicine) scored the highest, with 100% patients recommending the service in 11 months of the year.
The lowest annual percentage recommended was for ACU, with recommendations lowest at 60% in March 2019.

(Source: NHS England Friends and Family Test)

Leaders reported the response rate was improving following targeted action. Each ward was given a monthly target of number of responses which would help the service to achieve a target response rate of 35%. We saw evidence that from July to September 2019 the service met the 35% target.

Patients gave positive feedback about the service, the average ‘would recommend’ rate was 96%, at the time of our inspection.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that did not consistently meet the needs of local people and the communities served. It did not work effectively with others in the wider system and local organisations to plan care. Not all facilities and premises were appropriate for the services being delivered.

Managers did not consistently plan and organise services, so they met the changing needs of the local population. We saw the system to discharge patients was fragmented and complex, with a number of different pathways. Staff we spoke with told us it was difficult to access social care for patients and there was a lack of social workers working in the trust to help with this. There were a number of different teams such as discharge to assess and fast track teams. Different teams dealt with discharge for patients going to their own home or to nursing homes. This meant it was difficult for staff to plan discharge from hospital with the correct teams early in a patient’s stay.

We saw communication between the integrated discharge team and ward staff was not effective. The discharge team did not always attend ward board rounds. We saw staff were not clear on how to refer to the integrated discharge team and the discharge team stated staff did not always plan discharge early enough.

Leaders told us a service redesign was planned for dermatology services. However, this had been delayed as they were not able to gain consensus on the patient pathway across the local health economy on model redesign.

Not all facilities and premises were appropriate for the services being delivered. The environment in the discharge lounge had been improved since our last inspection. However, the bedded bay area was still partially used as an office for the discharge to assess team, which raised a potential confidentiality breach. We observed patient personal details left unattended in this area which was accessible by patients and members of the public or other external professionals such as ambulance staff who we observed in the discharge lounge.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff on the stroke unit referred patients to the early supported discharge team. This was a multidisciplinary team including speech and language therapists, physiotherapists and occupational therapists who offered patients support in the community to facilitate discharge from hospital. The support was not time-limited.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems.
Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff we spoke with stated mixed sex breaches were rare.

**Meeting people’s individual needs**

The service was inclusive, and staff made reasonable adjustments to help patients access services. However, the service did not always take account of patients’ individual needs and preferences, as care plans could not be tailored to individual needs.

Wards were designed to meet the needs of patients living with dementia. The service provided dementia friendly facilities on wards 21 and 22. We saw that ward 21 had a dedicated bay for dementia patients or those with delirium which contained specially adapted equipment such as a dementia friendly clock, large calendar, a radio and games. On ward 21 male dementia patients could access a day room which was equipped as a pub. There was also a bus stop in the centre of the ward and a wash area set up as a barber shop.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. The service participated in the ‘red bag’ scheme set up by the local clinical commissioning group for patients coming into hospital from a care or nursing home. The bags, which contained key paperwork, medication and personal items like glasses, slippers and dentures, were handed to ambulance crews by carers and traveled with patients to hospital where they are then handed to ward staff.

The service had four dedicated end of life care beds on the haematology ward. Patients were supported by the palliative care team who provided in reach into the ward.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff could access telephone and face to face interpreters and translators so that patients with limited or no English could access services in a safe and informed way. Information for staff on how to book translation services was on the trust intranet pages.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff used a red tray to highlight patients requiring assistance at meal times and a white jug lid to highlight patients on fluid restrictions. We saw menus included choices to meet religious preferences such as halal.

However, staff we spoke to told us they had limited access to training on supporting patients who had dementia or delirium. Therapy staff told us they were not able to access this training.

We reviewed care plans in six patient records and saw they did not include personal centred goals. Care plans were pre-populated on the electronic patient record system from drop down boxes. There was no space for free text. Therefore, care plans could not be adapted to individual needs or include person centre goals. On the stroke unit we found limited evidence of patient involvement in goal setting in their notes.

**Access and flow**

People could not always access the service when they needed it and care and treatment was not always provided promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were consistently lower than national standards.

At our last inspection, we found the service was struggling to cope with the number of patients requiring care. This meant that the hospital was often operating at full capacity. Additionally, patients were not always discharged as quickly as they should be. We found the same at this inspection.
Managers monitored waiting times, however, patients could not always access services when needed and did not always receive treatment within agreed timeframes and national targets.

**Arrowe Park Hospital**

Patients often stayed in hospital longer than they needed to.

From March 2018 to February 2019 the average length of stay for medical elective patients at Arrowe Park Hospital was 13.6 days, which is much higher than the England average of 5.9 days. For medical non-elective patients, the average length of stay was 7.0 days, which is higher than the England average of 6.1 days.

Average length of stay for elective specialties:

- Average lengths of stay for elective patients in gastroenterology and clinical haematology are both similar to the England averages.
- Average length of stay for elective patients in respiratory medicine is lower than the England average.

**Elective average length of stay - Arrowe Park Hospital**

![](chart1.png)

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

Average length of stay for non-elective specialties:

- Average lengths of stay for non-elective patients in general and respiratory medicine are both lower than the England averages.
- Average length of stay for non-elective patients in geriatric medicine is higher than the England average.

**Non-elective average length of stay - Arrowe Park Hospital**

![](chart2.png)

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

(Source: Hospital Episode Statistics)

Managers monitored the number of delayed discharges and knew which wards had the highest number. However, action to prevent and reduce delayed discharges was not effective. At the time of our inspection, there were 185 patients in the service who were medically optimised and fit for
discharge waiting for discharge. There were 189 'stranded' patients over 21 days length of stay. A stranded patient is a patient who has been in hospital for longer than seven days.

Senior managers reviewed stranded patients twice every week. However, they did not review all stranded patients as they only reviewed patients with a length of stay over 21 days. Leaders told us this was to focus on the area of greatest need. They told us they would review this and include all stranded patients once they had decreased the number of patients staying more than 21 days. Stranded patient reviews included senior managers and the integrated discharge team.

Managers and staff did not work together effectively to make sure that they started discharge planning as early as possible. Leaders acknowledged that discharge planning could be improved, and board rounds did not include sufficient multidisciplinary team challenge within discharge planning. Social workers used a different electronic patient record system to hospital staff, even though they could access the same system. This meant the discharge process was paper based and bureaucratic.

There was not effective working between the integrated discharge team and ward staff. The integrated discharge teams attended daily board rounds but these were held as they first came into work. Staff told us this meant the team were often not able to contribute effectively as they had not accessed up-to-date information before the meetings.

Staff in the integrated discharge team told us that ward staff did not plan for discharge early and waited until they were medically fit. We did not see expected date of discharge recorded in any of the patient records we reviewed.

At our last inspection, the service had introduced a practice of ‘boarding patients’. This meant that patients who had been identified as fit for discharge were moved to seated areas on other wards to free up a bed for patients awaiting admission. The service had introduced a standard operating procedure for this. Staff told us they used the procedure patients waiting for discharge went to the discharge lounge. However, we saw limited use of the discharge lounge during our inspection. On one ward staff told us the discharge lounge was not ‘appropriate’ for their patients. Staff told us most patients ready for discharge were moved to ward one, the surgical day case unit, the day before discharge.

Staff did not plan patients’ discharge effectively, particularly for those with complex mental health and social care needs. At the time of our inspection, the integrated discharge team had 183 patients waiting for discharge on their list, of these 104 were categorised as complex discharges. The longest length of stay in the service was 267 and 246 days. Staff told us this was due to issues finding placements in the community due to the patients complex needs. Staff told us many patients were discharged later in the day which led to bed moves later in the day or at night.

There was no specific ward for medically fit patients.

However, leaders told us there was executive level engagement with local community providers to try and tackle system wide issues. The service held daily telephone calls with the local clinical commissioning group. Managers attended a patient flow improvement group that was chaired by the Director Nursing. The service had identified ward one as a ‘ready to discharge’ ward to improve patient flow.

Staff could refer patients who required additional support or equipment to be able to return home to the discharge to assess team. This was a team of therapy staff who ensured all necessary rehabilitation equipment was in place prior to discharge. They would accompany patients home and assess the environment to ensure it was safe and all necessary equipment was in place.
The integrated discharge team included senior social workers to try and address issues getting social worker assessments for patients.

Managers told us the service had plans to ensure quality matrons led discharge planning for patients on their wards. Senior managers told us the discharge lounge was used effectively to move patients from the wards and ensure they were discharged.

The service had plans to introduce the administration of intravenous antibiotics to patients on the discharge lounge to prevent delays whilst patients waited for these. However, at the time of our inspection this was not in place as additional registered nursing staff needed to be recruited.

Staff used an electronic referral form for notification to assess and notification to discharge, these were reviewed by consultants on ward rounds.

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

From June 2018 to May 2019, the trust’s referral to treatment time (RTT) for admitted pathways for medicine was consistently lower than the England average. February 2019 saw the worst performance of 30.4% compared to 87.2% England average.

(Source: NHS England)

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

The following two 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>General Medicine</td>
<td>100.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>97.0%</td>
<td>96.6%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The following five specialties were below 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>Thoracic Medicine</td>
<td>91.7%</td>
<td>94.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>72.3%</td>
<td>81.0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>66.3%</td>
<td>92.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>60.8%</td>
<td>81.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>54.5%</td>
<td>95.0%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Senior managers told us that referral to treatment times in dermatology, rheumatology and respiratory services were the main areas of concern and focus for improvement. The service had an
action plan in place for rheumatology and had recruited a locum consultant as well as two junior doctors to offer extra sessions and address poor performance.

The dermatology service had identified long and short-term actions to improve referral to treatment times. They had recruited two locum doctors to offer extra sessions to patients. At the time of our inspection, the service was advertising for another substantive doctor to work with the consultant and offer extra sessions.

The sleep studies service used technology to conduct virtual reviews of patients to improve patient flow.

**Patient moving wards per admission**

The trust did not provide any data about individuals moving within the top five medical wards during their admission.

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

Following our inspection, the service provided information about ward moves between April and September 2019 as follows:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of moves into ward</th>
<th>Total time on ward</th>
<th>Average time on ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMU</td>
<td>143</td>
<td>228.59</td>
<td>1.61</td>
</tr>
<tr>
<td>APH Sleep Area</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCU</td>
<td>148</td>
<td>448.99</td>
<td>3.03</td>
</tr>
<tr>
<td>CGH Rehab</td>
<td>92</td>
<td>2,485.00</td>
<td>33.58</td>
</tr>
<tr>
<td>EDRU</td>
<td>22</td>
<td>37.97</td>
<td>1.73</td>
</tr>
<tr>
<td>LSU</td>
<td>237</td>
<td>1,221.26</td>
<td>5.17</td>
</tr>
<tr>
<td>MSSW</td>
<td>494</td>
<td>833.60</td>
<td>1.69</td>
</tr>
<tr>
<td>OPAU</td>
<td>283</td>
<td>1,021.49</td>
<td>3.66</td>
</tr>
<tr>
<td>Ward 21</td>
<td>339</td>
<td>3,595.12</td>
<td>10.83</td>
</tr>
<tr>
<td>Ward 22</td>
<td>349</td>
<td>4,076.19</td>
<td>12.10</td>
</tr>
<tr>
<td>Ward 23</td>
<td>149</td>
<td>1,289.60</td>
<td>9.08</td>
</tr>
<tr>
<td>Ward 24</td>
<td>257</td>
<td>2,294.16</td>
<td>9.14</td>
</tr>
<tr>
<td>Ward 25</td>
<td>143</td>
<td>2,092.78</td>
<td>15.28</td>
</tr>
<tr>
<td>Ward 26</td>
<td>394</td>
<td>3,077.87</td>
<td>8.12</td>
</tr>
<tr>
<td>Ward 27</td>
<td>279</td>
<td>3,500.39</td>
<td>13.11</td>
</tr>
<tr>
<td>Ward 30</td>
<td>156</td>
<td>1,561.35</td>
<td>10.48</td>
</tr>
<tr>
<td>Ward 32</td>
<td>543</td>
<td>2,963.74</td>
<td>5.48</td>
</tr>
<tr>
<td>Ward 33</td>
<td>423</td>
<td>2,939.46</td>
<td>7.05</td>
</tr>
<tr>
<td>Ward 35</td>
<td>421</td>
<td>3,299.86</td>
<td>7.93</td>
</tr>
<tr>
<td>Ward 37</td>
<td>273</td>
<td>1,150.43</td>
<td>4.23</td>
</tr>
<tr>
<td>Ward 38</td>
<td>520</td>
<td>2,628.31</td>
<td>5.09</td>
</tr>
<tr>
<td>Ward 43</td>
<td>5</td>
<td>3.93</td>
<td>0.79</td>
</tr>
<tr>
<td>Ward D1</td>
<td>9</td>
<td>25.90</td>
<td>2.88</td>
</tr>
<tr>
<td>Ward M1 Rehab</td>
<td>176</td>
<td>4,614.72</td>
<td>29.58</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,856</strong></td>
<td><strong>45,390.68</strong></td>
<td><strong>7.94</strong></td>
</tr>
</tbody>
</table>

**Patient moving wards at night**

At our last inspection we told the service it must act to reduce the number of patients moved at night. During this inspection we found staff moved patients between wards at night. Managers monitored patient moves but did not ensure moves between wards/services were kept to a minimum. On one day of our inspection, we saw four patients were moved at night between wards and a further five from the urgent medical assessment unit and one from acute medical unit.
From June 2018 to May 2019, there were 6,929 patients moving wards at night within medicine. Of these, 6,613 were at Arrowe Park Hospital and 316 at Clatterbridge Hospital.

The medical short stay ward (MSSW) at Arrow Park Hospital had the most patients moving wards at night (1,006) followed by the acute medical unit (AMU) (745).

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

The service sometime moved patients when there was no clear medical reason, or it was not in their best interest. Managers told us that patients with dementia and learning disabilities were moved at night sometimes and the final decision on patient moves was made by the bed coordinator.

Leaders acknowledged high number of moves at night and the need to improve bed management. They had submitted a business case to increase the number of bed coordinators, recruit senior nurses and introduce a new electronic system. However, though this had been approved it was not in place at time of inspection. The service was recruiting capacity manager posts to start in March 2020, whose role would be to work with wards to improve patient flow.

Ward sisters we spoke with told us they did not have a voice at bed management meetings and they were not given the opportunity to raise issues.

There were not effective arrangements for medical staff to review any medical patients on non-medical wards. Staff we spoke with told us that often patients who were medical outliers were not reviewed at weekends. We observed during bed management meeting there was no effective system for managing medical outliers on surgical wards. The service has a standard operating procedure for medical outliers to ensure the medical review of all patients. This stated all medical teams reviewed patients on outlying wards as part of their normal ward rounds. We reviewed seven patient records for patients who were medical outliers and saw none had been reviewed by a doctor over the weekend. We reviewed a further five patient records who were medical outliers and found that these were also not reviewed at weekends and for two patients they were not reviewed every day during the week. This meant there was a risk that patients may not receive the appropriate care and treatment required at weekends.

Managers told us they reviewed the number of medical patients on non-medical wards. They stated the allocated medical manager of the day discussed medical outliers at the bed management meetings and asked if they had been reviewed. Managers received an up-to-date list every day of which patients were considered suitable to place on a ward as an outlier. This was generated through the electronic patient records and nurses and doctors could identify on the record if the patient was suitable to be considered to be moved to another ward as an outlier. However, we observed three bed management meetings and saw that managers did not check if medical outliers had been reviewed. We examined the paper records of the week’s bed management meetings and there was no record that medical outliers had been discussed on the paper record.

Leaders told us the organisation had recognised the number of medical care beds needed to increase since the last inspection. The trust had supported the service to keep escalation areas open as part of permanent bed base.

The service had taken some action to address patient flow issues. For example, the older persons assessment unit had worked with local commissioners and the emergency department to develop an admission avoidance service led by specialist frailty nurses. Acute medics had created pathways for specific conditions that were across the local health and social care system. Locally GPs could send patients directly to assessment areas such as urgent medical assessment unit and older peoples assessment unit to avoid patients attending the emergency department.
Managers monitored patient transfers. We attended a bed management meeting and saw all patient transfers to wards at Clatterbridge Hospital were discussed. However, no staff from the Clatterbridge Hospital attended the meeting. We requested information on the number of patients transferred or discharged to Clatterbridge Hospital. Unfortunately, the service was not able to provide this.

Learning from complaints and concerns

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

At our last inspection we found the service did not always investigate complaints in a timely manner as outlined in the trust policy. Though this was still the case the response time had improved significantly since the last inspection. At our last inspection we saw the service took an average of 68.6 days to investigate and close complaints. At this inspection, the average time was 34.1 days. At time of our inspection the service had 15 open complaints. Managers told us that complaints that were not resolved within the expected timeframe were usually complex cases that required input from more than one department or division.

Patients, relatives and carers knew how to complain or raise concerns. We saw information displayed on wards on how to raise a concern. The hospital had a ‘patient experience hub’ near the main entrance, where patients and visitors could go for advice on how to raise concerns. The hub was staffed by volunteers, Healthwatch and the patient advice and liaison service. Volunteers from the patient advice and liaison service attended the wards on a Monday and Wednesday to get feedback from patients. This was an improvement from our previous inspection when we saw information on how to raise a concern was not displayed.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with were aware of the role of the patient advice and liaison service and knew how to sign post patients to it. At our last inspection, we saw the service had introduced a matron helpline. This had now been taken up and embedded across the whole organisation. Staff told us this had led to a reduction in complaints as concerns were resolved quickly at local level.

Trust level

From July 2018 to June 2019, the trust received 77 complaints relating to medicine (33.6% of total complaints received by the trust). The trust took an average of 34.1 working days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be dealt with within 30 working days.

However, the trust target for completing complaints prior to December 2018 had been 25, 45 or 60 working days (depending upon complexity).

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment and procedure</td>
<td>25</td>
<td>32.5%</td>
</tr>
<tr>
<td>Communication</td>
<td>21</td>
<td>27.3%</td>
</tr>
<tr>
<td>Medication</td>
<td>7</td>
<td>9.1%</td>
</tr>
<tr>
<td>Transfer and discharge</td>
<td>6</td>
<td>7.8%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>5</td>
<td>6.5%</td>
</tr>
<tr>
<td>Tests and results</td>
<td>4</td>
<td>5.2%</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>3</td>
<td>3.9%</td>
</tr>
<tr>
<td>Access and admission</td>
<td>3</td>
<td>3.9%</td>
</tr>
<tr>
<td>Patient slip, trip or fall</td>
<td>2</td>
<td>2.6%</td>
</tr>
</tbody>
</table>
Managers investigated complaints and identified themes.

A breakdown of complaints by site is shown below:

<table>
<thead>
<tr>
<th>Location/Site</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arwee Park Hospital</td>
<td>66</td>
<td>85.7%</td>
</tr>
<tr>
<td>Clatterbridge Hospital</td>
<td>5</td>
<td>6.5%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>4</td>
<td>5.2%</td>
</tr>
<tr>
<td>St Catherine’s Hospital</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td>Victoria Central Hospital</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

The divisional leadership team met weekly with the complaints team to review all complaints and responses for the service.

Managers shared feedback from complaints with staff in safety huddles and staff meetings. Learning from complaints was used to improve the service. All complaints identified as complex had a completed learning from patient experience (LEAP) action plan.

**Number of compliments made to the trust**

From July 2018 to June 2019, there were 25 compliments relating to medicine (19.5% of total compliments received by the trust).

A breakdown of compliments by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arwee Park Hospital</td>
<td>22</td>
<td>88.0%</td>
</tr>
<tr>
<td>Clatterbridge Hospital</td>
<td>3</td>
<td>12.0%</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

**Is the service well-led?**

**Leadership**

Leaders understood the priorities and challenges the service faced. The leadership team and structure had changed following our previous inspection. This meant leaders had not been able to fully implement and embed all necessary changes and improvements.

Leaders were visible and approachable in the service for patients and staff. Staff told us that divisional leaders and managers were visible and approachable. Managers felt supported by leaders and told us they saw them daily at bed meetings.

The service was led by a triumvirate of divisional director of nursing, divisional director and an associate medical director. Leaders told us the involvement of medical leadership in quality issues
and improvement plans had improved since our last inspection. They gave examples of support offered to junior doctors from medical leaders.

At our last inspection we told the service it should ensure there were sufficient managers at senior nurse and clinical lead level to run a service providing high quality sustainable care. Since then the service had invested in nursing leadership to support the triumvirate. Staff told us this meant that newly appointed matrons now focussed on quality and visited wards and clinical areas regularly to offer support and conduct audits. Ward sisters also worked clinical shifts to support staff on the ward. Matrons and ward sisters were supported by a team of associate directors of nursing.

Leaders supported staff to develop their skills and take on more senior roles. Matrons had attended the ‘Top Leaders’ programme which focussed on supporting them to develop skills to become effective leaders. Matrons spoke highly of support from divisional leadership and stated development opportunities for staff had improved at ward level. There was also a development programme for ward sisters which some had attended.

However, some staff especially below management level were not aware of trust leadership and executive team members. Staff told us there had not been visits from executive team members in their areas.

Leader told us that trust leadership expectations had increased disproportionately to the resource given to make the required changes.

Advanced nurse practitioners we spoke with told us there was a lack of leadership for them with a high turnover of managers. They told us they did not feel their role was valued by managers and leaders outside of their own wards or areas.

Vision and strategy

The trust had created a set of clear visions which were widely displayed throughout the service and which staff could clearly articulate. However, these were not supported by a clear organisational strategy.

The divisional strategy was described as ‘to provide high quality and safe care across all areas by utilising best practice, the skillset of all staff members and the opportunities presented through technology’ and to ‘empower its workforce to develop sustainable improvements in care, patient flow and communication flow pathways’.

The divisional strategy was described by leaders as a work in progress. The service held a divisional strategy away day for staff of all grades and disciplines. It had also held away days at speciality level with involvement of all staff. From this staff engagement, the service had drawn up divisional priorities with associated action plans. We reviewed the strategy statement and saw it covered key areas of workforce, quality and safety, unplanned patient flow, planned patient flow and finance.

However, leaders acknowledged that the divisional strategy sat in isolation and was not linked to an overall trust strategy. This was because the trust strategy, whilst still in date, did not fully reflect recent changes in vision and strategy across the organisation.

Culture

Staff satisfaction was generally high. The service gave staff opportunities to raise concerns or provide feedback. However, some staff groups told us they did not feel respected, supported and valued.

Leaders reported culture had improved since the last inspection. The service used culture reviews to identify cultural issues within some teams and departments. Cultural reviews had been completed in
the integrated discharge team and accident and emergency department. Staff said they felt able to speak up and they had seen changes as a result of cultural reviews within the service. Managers told us staff were given open and honest feedback following these reviews and feedback from staff to managers stated this had increased their trust in the organisation.

Managers reported that support from trust leadership to divisional and service level had improved. This meant there was more understanding at executive level of issues at ward level and much clearer direction from leaders.

Staff we spoke with were proud to work on their wards and proud of the level of care they provided. Many staff told us they would be happy for members of their own family to be cared for on their ward. Staff reported the culture in acute medicine had improved with increased stability, as staff were no longer leaving.

Managers told us that in the last 12 months staff attitude towards quality improvement had changed and there was now an openness to ideas and a willingness to engage in improvement projects.

Staff reported an improvement in the working relationships with other departments in the hospital, especially the emergency department. Staff told us there were positive working relationships between the wards and the emergency department and the new structure supported this. Staff told us they were able to challenge each other constructively and there was a supportive cohesive culture.

Staff we spoke with were aware of the newly created organisational values and behaviours. They told us they felt able to challenge when staff did not display these behaviours.

The service nominated teams and individuals for the trust ‘Together Awards’ to recognise good practice. The staff on ward 24 were nominated in the patients choice and team of the year categories.

Staff we spoke with were aware of the role of Freedom to Speak Up Guardian and knew who they were and how to contact them. We saw detail on the Freedom to Speak Up Guardian and how to contact them were displayed in the patient experience hub. A Freedom to Speak Up Guardian works alongside the trust’s senior leadership team to ensure staff have the capability to speak up effectively and are supported appropriately if they have concerns regarding patient care.

However, some staff told us they felt valued and supported within their teams but not by the wider service or organisation.

Advanced nurse practitioners we spoke with felt they were not respected by other nursing staff and they were not listened to when they raised issues of patient safety. They told us they felt the role was not understood or valued and they were not given time to attend engagement events such as drop ins with trust executives.

Some staff told us they found harms meetings ‘challenging’ as they attended their own slot and presented to senior staff. They felt they did not have the opportunity to stay and learn from others.

**Governance**

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, we found local governance processes were not always fully effective. Not all key issues identified at the last inspection had been acted on to improve medical care services.

At our last inspection we highlighted a number of ‘must’ and ‘should’ actions for the service to make improvements as they were in breach of a regulation of the Health and Social Care Act 2008 or if the action was not addressed could breach the act. At this inspection we found three 'must' actions and
four ‘should actions which were not fully completed, despite the service having an action plan in place.

For example, at our last inspection we told the service it must ensure that patient records were always kept secure. At this inspection we found record trolleys containing patient records left unsecured in four areas and computer screens displaying patient information in one area.

We found areas of poor practice where audit and monitoring processes were in place. Therefore, we could not be assured that governance processes were effective. For example, we found substances hazardous to health stored in unlocked rooms on four wards. This was highlighted on the trust risk register and ward risk assessments reviewed in December 2018. The service told us compliance was audited as part of the health and safety audit and perfect ward audit and through risk management and health safety committees.

However, we also found the governance processes supported some key improvements. Leaders told us that they got data to enable them to analyse performance through perfect ward and matron audits. They gave the example of improvement in nutritional screening compliance. This was monitored weekly and discussed at the quality board and compliance had increased to over 90%.

The division was divided into four directorates each with its own triumvirate of leaders and governance structures. Divisional patient safety and quality boards had a representative from each directorate. The clinical directors, medical director and divisional director meet weekly as a leadership team to review performance.

Managers attended a monthly divisional performance review meeting where key targets and patient flow were reviewed, as well as the divisional dashboard. Information from patient safety and quality boards and the harms panel reports were also reviewed at the performance review meeting.

Matrons reported oversight by triumvirate at divisional level had improved and governance structures were stronger. Matrons stated governance meetings were useful and involved all members of the team to improve risk management. Managers told us the service ‘felt safer’ as governance structures supported them to manage quality, safety and performance in the service.

The service reviewed mortality and morbidity through the structured judgement review process. Mortality reviews are important as they facilitate learning from deaths that have happened in the department, particularly when a death may have been avoidable. The trust had a target for 100% of deaths to have a mortality review. Every death in the service was allocated to a consultant for an initial review who then identified any issue which meant the death should be reviewed through this process. However, we found that the learning from deaths policy did not state a timescale for reviews. This meant there was a risk that senior managers were unaware of how reviews were progressing and whether there were outlying cases with very long delays. During our well led inspection, we reviewed 15 deaths and saw the average time from death to primary mortality review was 65 days.

**Management of risk, issues and performance**

Though leaders and teams used systems to manage performance, these were not always effective. Staff could identify risks for the service, but we found there was little local ownership of risks and actions.

Once risks were identified at ward level the risk department was responsible for ensuring the risk was added to the divisional risk register. Managers told us the risk department followed up any actions either on the review date identified or after six months. Managers told us the divisional director of nursing and senior nurses met weekly with the divisional risk management team to review
severe and moderate risks and escalated these to the divisional risk committee through the trust patient safety and quality board. The weekly associate director of nursing reports identified all incidents and outstanding risks, and a risk reminder was sent electronically to risk owners to highlight when an action was due.

Actions identified in the risk register did not always fully mitigate the risk or risks were not acted on in a timely manner. We reviewed the risk register and saw that not all risks identified had action to address the risk, target dates or persons responsible assigned to actions. One risk for general medicine stated no controls were in place and no progress had been made, another had no action plan. A risk relating to replacement of call bells had a target date of 2029.

Managers and leaders attended a daily divisional safety huddle which included a review of incidents, risks and staffing for the previous 24-hours and the next 24-hours. There were also daily safety huddles on each ward to share information at ward level.

There was a trust wide safety summit open for any member of staff to attend and individuals were encouraged to present at this. However, staff told us it was difficult for ward-based staff to attend as they could not get time away from the ward.

The service had a system of weekly monthly and quarterly audits as part of perfect ward audits to help improve performance and standards in care. However, this was a relatively new system and not yet fully embedded. Weekly audits were completed by ward sisters and were a mix of record checks and observational audits. These were followed by monthly matrons audit and quarterly audits by the associate directors of nursing.

These audits were reviewed every month as part of a perfect ward audit meeting attended by the divisional directors of nursing and themes identified and action plans put in place.

The service had a falls steering group which developed and monitored the falls improvement plan. This was attended by doctors, nurses and therapy staff and met every eight weeks to review progress on improvement plan.

**Information management**

The service collected data and analysed it. However, the information used in reporting, performance management and delivering quality care was not always timely or used to improve performance.

We requested matron monthly audit results for July to September 2019. These showed that audits were completed in 18 out of 21 areas in July 2019 and 19 out of 21 areas in August and September 2019. The average audit score was 89.93%. However, as audits were not consistently completed in all areas this meant leaders and staff in those areas may not always receive information to enable them to challenge and improve performance.

The information from monthly matrons audits did not drive improvement in performance in all areas. For example, in some areas such as ward 31 and 23 the performance against the monthly matron audit declined over the three months.

Arrangements for the confidentiality of patient identifiable data and records were not always robust. We found patient notes stored in unlocked trolleys on four wards and found patient information displayed on unattended computer screens on two occasions. We also saw that patient information was left unattended on the discharge lounge.

**Engagement**
Leaders and staff actively and openly engaged with patients, and staff to plan and manage services. However, some staff reported they had limited opportunity to engage with the service and wider organisation to influence service development.

Ward sisters held weekly drop in sessions for patients and relatives and this was advertised by posters on the wards. The service ran a 24-hour seven day a week ‘matron helpline’ for patients and relatives to speak to a matron to discuss any questions or concerns. This model had been adopted by the whole organisation after starting in medical care services.

Ward sisters had developed ways to engage with staff and to encourage staff to engage with each other on their wards. For example, the team notice board on one ward has a focus on team work for that week. Another ward held an informal monthly coffee morning with the matron. Information from the coffee morning was shared in the ward newsletter.

Medical leaders had developed their own closed social media groups to share ideas, knowledge and training opportunities.

Managers told us that from November 2019 the service was starting a forum for registered nurses. This would provide nurses an opportunity to meet executives and leaders and share ideas for service and organisational development.

However, at the time of our inspection opportunities for staff to share ideas with senior managers were limited. Some staff we spoke with told us they had limited opportunities to discuss ideas with managers and the recent away days were ‘a one off’. Therapy staff told us they did not have opportunities to get involved in audits or service improvement initiatives.

**Learning, continuous improvement and innovation**

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged quality improvement.

Since our last inspection the service had completed a number of quality improvement projects. For example, the service had worked to improve compliance with nutritional screening on ward. Each ward now had its own housekeeper and screening was monitored as part of the matron checklist and discussed at safety huddle.

The service had a number of continuous improvement projects such as length of stay and falls. The falls prevention group were reviewing alternatives to sleep medication to reduce falls at night such as introducing eye masks and lavender pillows.

Managers told us that all matrons had been booked onto a quality improvement training course. The service had introduced a ‘bright ideas’ email for all staff to share any ideas they had for quality improvement projects or to improve the patient experience.

The service used ‘quality buses’ on wards to promote improvement projects or awareness campaigns. These were cardboard information stands shaped as buses which travelled round wards to inform staff of projects and share information.

Individual specialities organised study days in their own areas such as cardiology. A respiratory nurse consultant was part of the national British Thoracic Society group developing new guidelines for services.
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.

Surgery

Facts and data about this service

The surgery division provides non-elective, elective and day case surgery for several specialities. These include general surgery, ear, nose and throat, orthopaedic, ophthalmology, urology, colorectal and maxillofacial surgery.

The trust has 22 main operating theatres covering a range of specialties across Arrowe Park Hospital and Clatterbridge Hospital.

There are nine theatre suites at Arrowe Park Hospital, each with attached anaesthetic room. The hospital has a 12 bedded recovery area including one dedicated paediatric bay. Three of the theatres are laminar flow for implant surgery.

The trust has eight surgical wards at Arrowe Park hospital and one surgical ward at Clatterbridge hospital. The trusts speciality services include; upper gastrointestinal surgery, vascular surgery, colorectal surgery, urology, trauma and orthopaedics. The trust has 19 surgical assessment unit and 165 inpatient beds at Arrowe Park hospital and 26 inpatient beds at Clatterbridge hospital.

The division has 22 theatres including a dedicated Women's and Children's theatre suite. See details below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Theatre Identification</th>
<th>Specialty</th>
</tr>
</thead>
</table>


The trust had 33,907 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 10,578 (31.2 %), 18,848 (55.6%) were day case, and the remaining 4,481 (13.2 %) were elective.

(Source: Hospital Episode Statistics)

We planned our inspections based on everything we know about services including whether they appear to be getting better or worse.

We inspected the division of surgery between 15 and 17 October 2019. Our inspection was unannounced. As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

During the inspection the inspection team visited the following areas:

- Ward 10, 11 and 12 - Trauma & Orthopaedics Ward
- Wirral Acute Femoral Fracture Unit
- Ward 14 - Colorectal Ward
- Ward 18 – General Surgery
- Ward 20 - Urology Ward
- Emergency Surgery Assessment Unit
We visited several theatres, the recovery areas and anaesthetic room. We also observed a morning ward handover, safety huddles, multidisciplinary team meetings, and a workforce meeting.

The inspection team spoke with 12 patients and carers who were using the service, and 69 members of staff including managers, consultants, nurses, healthcare assistants and administrative staff. We reviewed seven patient records and six WHO checklists. We observed staff interactions with patients, team meetings and huddles.

The service was last inspected in March 2018, with the report published in July 2018. Surgery was previously rated as requires improvement.

### Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

#### Mandatory training

##### Mandatory training completion rates

The service provided mandatory training in key skills to all staff and made sure everyone completed it. The mandatory training was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

The data provided by the trust prior to the inspection showed that the majority of staff had completed mandatory training. Updated figures provided by the trust after the inspection showed that 90% of nursing staff and 74% of medical staff had completed basic life support training. The updated figures showed that only half of eligible staff had completed intermediate life support training, but there were only four eligible staff across the trust.

The staff and managers we spoke with confirmed that mandatory training was monitored. Ward sisters attended regular workforce assurance meetings ran by the matron to discuss training and appraisals. Whilst there was no protected time for staff to complete training, staff told us they could claim time back if they completed the training in their own time.

Mandatory training included a sepsis module which was part of the deteriorating patient training.

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

#### Trust level

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>352</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>351</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>332</td>
</tr>
<tr>
<td>Fire Safety Level 2</td>
<td>324</td>
</tr>
<tr>
<td>CPR</td>
<td>323</td>
</tr>
</tbody>
</table>
In surgery the 95% target was met for two of the ten mandatory training modules for which qualified nursing staff were eligible.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety Level 1</td>
<td>125</td>
<td>130</td>
<td>96.2%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>113</td>
<td>130</td>
<td>86.9%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>113</td>
<td>130</td>
<td>86.9%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>113</td>
<td>130</td>
<td>86.9%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>CPR</td>
<td>94</td>
<td>130</td>
<td>72.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>89</td>
<td>130</td>
<td>68.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security Awareness Level 1</td>
<td>78</td>
<td>130</td>
<td>60.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>63</td>
<td>130</td>
<td>48.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>20</td>
<td>129</td>
<td>15.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for one of the nine 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.

The trust had developed a clear safeguarding pathway for staff to follow, details of which were available on the intranet. This listed all the different types of abuse patients could be at risk from. Staff we spoke with could describe how to raise a safeguarding incident and could provide examples of where they had raised concerns in the past.

Staff were aware of female genital mutilation and Prevent strategies.

Mental Capacity Act and Deprivation of Liberty Safeguards training was provided as part of the trust's protection of vulnerable people training. It was also included in the induction programme for all new starters.

Most nursing and medical staff were up to date with the training requirements in this area.

Safeguarding training completion rates

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

Trust level

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>337</td>
</tr>
</tbody>
</table>

In surgery the 95% target was not met for the one safeguarding training module for which qualified nursing staff were eligible.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>115</td>
</tr>
</tbody>
</table>

In surgery the 95% target was not met the one safeguarding training module 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, with staff not always using control measures to protect patients, themselves and others from infection. The service had systems to identify surgical site infections, albeit that it was undertaking the minimum requirements. Staff kept equipment and the premises visibly clean.

There were sufficient hand gel dispensers throughout the ward areas and signs on the wards reminding staff, patients and visitors to clean their hands when entering and leaving the ward. We observed staff observing good hand hygiene practice, and challenging people visiting the wards to clean their hands. However, the performance dashboard for the division showed mixed compliance with hand hygiene protocols when this had been audited. Between June 2018 and January 2019, compliance rates varied between 75% and 85% against a target of 95%. Audit data between February and April 2019 was missing, but the May 2019 rates had improved to 92% (albeit that this was still below target).

The colorectal ward had had a number of cases of Clostridium difficile in early 2019. The service was reviewed to look at what changes could be made to help reduce incidences and a case was presented to the executive board. Data showed that the number of cases had decreased from a high of 19 in April 2019, to six in August and 3 in October. This showed an improving figure, albeit that the cumulative year to date total was above the trust’s planned trajectory by eight cases.

There was no isolation area for infected patients in theatres or recovery. Infected patients were recovered in either theatre or the anaesthetic room by recovery practitioners supported by an anaesthetist.

Public Health England encourage trusts to report surgical site infection data against 17 categories. Four of these (all orthopaedic) are mandatory – there is a requirement to conduct surveillance for at
least one orthopaedic category for one period in the financial year. The remaining 13 categories can be reported against on a voluntary basis. The trust provided evidence that it had done this, reporting reduction of long bone fracture and Repair of Neck of Femur in January to March 2019, and hip fracture data for the same period in 2018. The trust had not reported against any of the other voluntary data sets. There was insufficient evidence to establish whether the service was an outlier for surgical site infections when compared to other organisations. However, the data from January to March 2019 showed an 8% infection rate for long bone fractures, which is high. There was no review of the reasons for the infections or evidence of immediate action to address these.

The trust told us that in order to monitor all surgical site infections, the division planned to recruit a surgical site infection surveillance nurse working across trauma and orthopaedics and general surgery (and linking with the trust’s infection prevention control team). Meetings would be established to monitor all possible surgical site infections. The service had planned to recruit to the post by January 2020.

We saw some items of equipment that had “I am clean” stickers on them. Whilst this was not the case for all equipment, especially in theatres, the equipment did appear clean. The theatre environment was cleaned by night staff and we saw evidence that operating tables were cleaned after each procedure.

We observed staff wearing personal protective equipment when necessary.

Infectious patients could be placed in side rooms where necessary. Signs were placed on doors highlighting to staff and visitors that there was an infectious patient and what processes to follow.

We saw posters reminding staff about the bare elbow the elbow protocol and staff adhered to this.

Sinks within the ward area and side rooms had non-touch taps.

The division had its own sterile services unit. Surgical equipment could be fast tracked for decontamination within six hours (12 hours was the standard turnaround time).

A theatre porter had developed their own pocket-sized personal protective equipment kit that contained gloves, apron and alcohol wipes so that these were easily to hand should they be required.

The service had criteria for which patients would undergo meticillin-resistant Staphylococcus aureus screening pre-surgery; for example, all patients requiring general anaesthetic were screened, as well as orthopaedic patients.

Environment and equipment

The maintenance and use of most facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the service did not have suitable pre-operative assessment facilities to meet the needs of patients or staff.

The pre-operative assessment unit had recently been relocated to another part of the hospital and was now within the cardiovascular unit. However, hospital signage had not been updated and the new unit was difficult to find. Staff on the unit told us that patients had complained about this.

The pre-operative unit was not patient or staff friendly. The reception desk was small and placed next to a busy doorway – staff told us the door often banged into patients waiting at the desk. The patient waiting area was shared with the cardiovascular unit. Staff told us it became very crowded when a cardiovascular clinic coincided with pre-operative assessments; they said it was “standing room only” as there were not enough chairs or space for them.
The pre-operative waiting area could not be seen by the reception or assessment staff, and there were a number of entrances and exits to the area which meant that patients could leave without being noticed by staff, which we were told had happened.

There were no signs displaying waiting times in the pre-operative area. Staff also told us that it was difficult to communicate between reception and assessment staff as they were in different parts of the unit.

The two pre-operative assessment rooms were small and cramped. There was no room for a patient couch which meant that if a patient collapsed, or felt faint, they would have to lie on the floor. The cramped nature of the environment also meant that staff could not easily leave the room if a patient became violent or aggressive. Conversations with an adjoining cardiovascular treatment room could also be overheard. The were no alarms in either of the assessment rooms.

There were two assessment staff and one clinical support worker in the pre-operative assessment unit. Whilst the assessment rooms were fixed and used solely for that purpose, the room used by the clinical support worker to check height, weight and bloods could change on a daily basis and it had been moved to other parts of the hospital. Staff told us that not only did this make communication between the team difficult, but it was inconvenient for patients to have to walk between different areas of the hospital. It also meant that there was an increased chance of patients getting lost. Staff told us that a patient appointment had to be cancelled on the day as there was no room available for the clinical support worker to carry out their duties.

Staff in the pre-operative assessment area told us that in the seven weeks since they had relocated, the drains had blocked and flooded twice.

The colorectal ward had been moved from Ward 17 to Ward 14. The environment was appropriate for colorectal patients then it's previous location, with a greater number of side rooms (all with ensuite facilities). There was also piped oxygen and suction by each inpatient bed.

There were resuscitation trolleys in all wards and in theatres, and appropriate checklists had been completed (asset tags matched those on the checklist). Most trolleys had a large poster above them detailing the contents of each drawer. Defibrillator checks had been completed and the portable oxygen cylinders we checked were full. However, none of the trolleys contained guidance from the Resuscitation Council (UK).

Staff disposed of clinical waste safely, with theatre waste disposed of in accordance with the Association for Perioperative Practice best practice guidelines.

The division had a surgical day unit (ward 1). However, the ward had been converted to a medical escalation ward. There were no surgical patients on this ward. Day patients were now either seen in the Surgical Elective Admissions Lounge and then transferred to a surgical ward if they needed additional care. Whilst the unit had one day case theatre, this was no longer used, and all patients were seen in the main theatres or at the trust’s other hospital.

Every ward had a staff board on entry displaying the name and photograph of the ward leadership team (Sister and Matron). It displayed visiting times, and what the different coloured staff uniforms meant.

We checked patient toilets on some of the wards. These were clean, and all those we checked contained an emergency pull cord. There were also wheelchair accessible toilets on the ward we visited.

Most of the equipment we checked had been safety tested. The anaesthetic machines had been appropriately checked and signed for as per the Association of Anaesthetists of Great Britain and
Ireland (AAGBI) guidelines. Three of the theatres were laminar flow for implant surgery. The division also had a planned preventative maintenance programme to review and maintain the theatre environment and the equipment.

Whilst the theatre environment appeared clean, we observed holes in the walls and large chunks missing from wooden door frames.

There were multiple entrances and exits to each theatre and we observed staff entering and exiting using various routes during surgery. Whilst the main door had a lock, we only observed this being used on two occasions (out of the six we observed). Best practice was for staff to only use one door.

All Control of Substances Hazardous to Health chemicals were securely locked away.

Sharps bins had been correctly assembled and labelled.

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

**Assessing and responding to patient risk**

Staff did not always comply with the requirements of the surgical safety checklist and so were not minimising risks in this area. Staff identified and quickly acted upon patients at risk of deterioration.

Despite there being large posters in each theatre displaying prompts for the surgical safety checklist, staff did not always adhere to these. For example, we observed six surgical safety checklists. During five of these, staff did not always introduce themselves. During one checklist a member of the surgical team was not present for sign in and not all staff were paying attention during another checklist we observed. The trust’s own audit data (based on a review of the theatre documentation) showed that most staff completed all aspects of the checklist most of the time.

The service had introduced an initiative called ‘Stop Before You Block’, a campaign aimed at reducing the incidence of inadvertent wrong sided nerve blocks. Posters about the initiative were in each anaesthetic room but they were not prominently positioned. We observed one block during the inspection and staff followed the correct process.

Ward 14 (Colorectal) operated an enhanced recovery programme for certain colorectal patients. This was developed following patient feedback a number of years ago to look at what the service could do differently.

The colorectal team had developed a guide for patients had recently been signed off by the division and was due to be available for patients. The guide provided details of how patients could “play an active part in their recovery and to work in partnership with the colorectal team to achieve this aim”. The guide provided information on what patients should consider before surgery; stop drinking and smoking, gentle exercise and a good diet. It also advised patients to bring in all home medicines for review during the pre-operative assessment. Detailed information was provided about what patients could expect on the day of the procedure and immediately afterwards, including how to care for their stoma with support from the stoma nurse specialists. Patient were called at home after they were discharged. The enhance recovery programme also included access to a clinic, held three times a week, that patients could attend for advice following discharge. Contact numbers given for the Macmillan nurse team, ward staff and the stoma specialist nurse.

The division had targets for patients having surgery for fractured neck of femur within 36 hours of admission. Minutes from the Neck of Femur multidisciplinary meetings looked at data surrounding those patients that failed to have surgery within 36 hours and whether the “fails” were unavoidable. Between June and August 2019, between 86% and 92% of the “fails” were unavoidable.
Patients attended a pre-operative clinic for colorectal surgery once a week. The team were looking to increase the number of clinics to be held twice a week.

There was one designated emergency theatre that was staffed 24 hours a day, seven days a week.

We saw sepsis screening protocols in line with the Sepsis Six pathway (a set of six tasks to be completed within an hour of identifying probable sepsis) with clear flowcharts available in the wards for staff to follow. Staff also had access to the trust’s sepsis outreach team.

The sepsis pathway was embedded within the electronic patient record system. This allowed the division to audit whether staff followed the correct pathway. Staff showed us the most recent audit results during the inspection. This showed that within the first hour of staff suspecting a patient had sepsis only 72.9% of blood cultures were taken, 78.9% of antibiotics administered, and 73% intravenous fluids given (against a target of 90%).

The trust did not use sepsis kits (small ready made up bags containing most of what staff would need to start managing a patient with suspected sepsis).

Staff in the pre-operative assessment clinic carried out assessments to check that patients were suitable for surgery. Checks included whether patients had a history of heart problems, blood clots or diabetes, and whether they had allergies, including to anaesthesia. Patients were asked how much they smoked and drank. They also had an assessment of their respiratory reserve, their home situation (whether there was anyone to care for them after discharge) and an infection screen (where appropriate). The completed assessment checklist was then sent for anaesthetic review for final sign off.

We observed staff carrying out patient safety huddles. These huddles followed a set checklist where staff were asked to provide information on patients including any that were at risk of falls, deterioration or pressure ulcers. Staff also checked those patients that had similar names, required four hourly repositioning and any outstanding nutritional assessments. The meeting was well attended with staff contributing and paying attention.

The service used a recognised risk assessment tool to identify deteriorating patients (National Early Warning Score 2). This was linked to the electronic patient record and it was easy to track and view a patient’s early warning score (these would also be colour coded – red, amber, green - depending on whether the patient was deteriorating). The trust used portable electronic observation machines that had, in the past, automatically updated patients’ electronic record, including early warning scores. However, the trust had found that problems with the WIFI meant that these observations were not always feeding through to the patient record. Therefore, patients’ observations were entered manually.

Patients on ward 14 were observed, as a minimum, every four hours even if their observations were within normal range. This could be increased depending on their needs and observations.

Due to the large number of medical outliers on the surgical assessment unit, the service had stationed a medical consultant on the unit to help care for these patients.

Nurses had access to the critical care outreach team to help assess deteriorating patients.

Staff on ward 14 told us that some of the side rooms were quite a distance from the nursing station. They told us that they risk assessed to make sure that only suitable patients were placed in these rooms.

The service had access to psychiatric services if required. They told us that there were no major issues regarding delays in psychiatric reviews.

There was a major haemorrhage policy and pathway displayed within the theatre area.
The service conducted audits about whether a patient’s risk of venous thromboembolism had been assessed within 12 hours of the decision to admit. Between April 2018 and January 2019, the results were below the division’s target of 95% (between 22% and 85%). However, between February 2019 and May 2019, the trust had achieved over 96%.

**Nurse staffing**

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction. There were systems and processes in place to ensure adequate staffing. However, the service’s sickness rates were increasing.

The wards we visited during the inspection were largely up to their staffing complement. However, staff told us that they were often moved to cover pressure areas in other departments, such as medical outliers in ward 1. They told us that this caused frustration. One nurse told us that difficulties sometime arose when they had a large number of patients requiring one to one attention. The staff moves meant it could be difficult to provide safe care for other patients. The nurse told us that that they had raised this as an issue, and further healthcare assistance support had been provided. However, one member of staff told us that moving of staff was affecting morale within the teams.

Staff on ward 20 told us that to help with pressures on staffing, clinical support workers had undertaken additional training in taking observations and bed baths, to help relieve pressure on nursing staff.

When necessary, managers deployed bank staff to maintain safe staffing levels. Most bank staff were the trust’s own employees who had been through the appropriate training and induction modules. The service rarely used agency staff.

The division had acted on the previous issues of vacancies within the service, and many vacant posts had been filled. For example, ward 18 had previously seven nursing vacancies. Two had returned from long term leave and one new person had started. Three new registered nurses were due to start in March 2020.

There was a daily staffing meeting to discuss staff numbers. We attended one meeting where ward sisters and the matron was present. They discussed which staff were due to complete mandatory training and whether there were sufficient staff to cover the number of patients in the wards. They discussed any patient requiring one to one support (which could affect staffing requirements) and when these patients were due to be discharged. We saw managers discussing the need to call their bank staff provider in order to fill gaps in the healthcare assistant rota for ward 15.

We observed two nursing handovers. One was conducted on the surgical assessment unit on a small table in the corridor. This was a noisy environment and the staff were interrupted by others asking questions unrelated to the handover. However, during both handovers, staff discussed the patients’ past and current health conditions, their social situation and what tests and assessments were outstanding. We also observed the handover of one patient were staff raised concerns about their low mood.

However, sickness levels for nursing staff was increasing. We asked the leadership team about this. They acknowledged the issues but there was no further information provided about what steps were being taken to address this.
Trust level

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

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>1,339.3</td>
<td>7%</td>
<td>10%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>469.0</td>
<td>8%</td>
<td>9%</td>
<td>5.7%</td>
<td>18,381 (6%)</td>
<td>1,760 (1%)</td>
<td>12,180 (4%)</td>
</tr>
</tbody>
</table>

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

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

Sickness rates

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives show a shift from December 2018 to May 2019.

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

Agency staff usage
Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives show a downward trend from July 2018 to December 2018.

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

Medical staffing

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

Theatre staffing was above that recommended by the Association for Peri-Operative Practice.

Each patient was allocated a specific consultant on assessment to manage their care during their stay.

The service always had a consultant on call during evenings and weekends.

However, there were very high levels of turnover for medical staff within surgery (22% against a target of 10%), and vacancies were on the increase.

There were also lower levels of middle grade doctors and registrars compared to the England average which was potentially affecting the ability of medical staff to complete discharge letters in a timely manner. The majority of medical staff were consultants. Staff told us that as most of the consultants were in theatre throughout the day, discharge letters could not always be signed until surgery had finished.

Trust level

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

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Surgery annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>June 2018 to May 2019</td>
</tr>
<tr>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Page 149
Medical staffing rates within surgery at the trust were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness, agency usage rates.

**Vacancy rates**

Monthly vacancy rates over the last 12 months for medical staff shows a shift from December 2018 to May 2019. This could be an indicator of change.

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

**Bank staff usage**

Monthly bank hours over the last 12 months for medical staff shows a downward trend from August 2018 to December 2018. This could be an early indicator of improvement.

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

**Staffing skill mix**
In March 2019, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher than as the England average.

**Staffing skill mix for the wholetime equivalent staff working at Wirral University Teaching Hospital NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>53%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>24%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>14%</td>
<td>11%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

**Records**

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

The division used electronic records for patients. There appeared to be sufficient terminals for staff to access records. Whilst we most of these terminals were locked with a password, two terminals on the surgical assessment unit were not. One did not display patient identifiable information, another did (name and age of the patient). We returned to the unit later in the inspection and all terminals were locked. Therefore we were satisfied that this did not appear to be a systemic issue.

We reviewed seven records. As they were electronic, they were easily to read and understand. The records we reviewed contained details of allergies (where necessary) and patients had had the correct assessments recorded such as falls, venous-thromboembolism, fluid balance and nutritional assessments. Staff could also highlight such things as infection risk, or whether a patient had a deprivation of liberty safeguard protocol in place.

The service still used some paper records for consent forms and do not attempt cardiopulmonary resuscitation form that had not yet transfer to the electronic system. There were record trolleys on each ward for these records and we saw that these were locked when not in use.

Most wards had a large electronic patient tracker near the nursing station that showed which patients where in which beds, what their early warning scores were, current length of stay and any risks such as dementia or safeguarding concerns. When this was in use, the screen was minimised to protect patient data.

We reviewed two patients who had followed the neck of femur pathway and saw that these had been completed, with appropriate assessments carried out at the right time – these included patients having surgery within 36 hours of admission.
Discharge letters were sent automatically to patient GPs following discharge. However, we reviewed one medicines administration record for a patient prescribed thickeners. Staff had not been recording that the thickener had been administered. We raised this with the ward pharmacist who confirmed the administration should have been recorded.

**Medicines**

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

The medicine rooms we checked could only be accessed via a keypad lock. We checked some of the equipment in the room and they were within their expiry dates. Contact details for pharmacy staff were clearly visible. The medicine rooms in the surgical assessment unit contained pathways for the antibiotic treatment of community acquired pneumonia, paracetamol overdose, and the safe use of insulin.

We saw staff wearing red aprons during drugs rounds reminding staff and visitors not to interrupt them whilst there were dispensing medication.

The division had previously had an issue surrounding the documentation of controlled drugs. Of the four audits conducted between April 2018 and November 2018, the division’s compliance was less than 39% on all occasions. Compliance had improved during an audit in January 2019 (94%) and we also saw that the controlled drugs log book was appropriately completed within theatres, and the controlled drugs cupboard was locked, with the keys held by an appropriate person.

Intravenous fluids were stored correctly in theatres in a key coded room.

We saw one example in the surgical assessment unit where the medicines fridge thermometer had broken and a new one took 11 days to arrive. No fridge temperatures were recorded during this period, and there was no record of what action was taken to mitigate any risk.

The division’s performance dashboard showed that staff were not meeting the target (90%) of ensuring patients had their medicines reconciled within 24 hours of admission. Between April 2018 and May 2019, compliance rates varied between 66% and 88%.

In the six months to May 2019, the division was meeting its target (95%) for antimicrobial stewardship.

**Incidents**

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Incidents were raised on an electronic system. Staff could include their email address if they wanted feedback on the outcome of any investigation. Staff we spoke with knew how to raise an incident. Whilst most staff told us they had received feedback, three told us that they had not.

Staff we spoke with understood what the Duty of Candour meant, with one member of staff providing an example of where they had followed the process.

Staff meetings had largely been replaced with the patient safety huddle, and we were told that incidents would be discussed during huddles. We saw evidence of incidents and concerns being discussed in ward 14 and the surgical assessment unit (following incidents of Clostridium difficile and
reminded to staff to follow nutritional assessment protocols). However, this was not universal throughout the surgical wards. The safety huddle minutes we reviewed in other wards did not discuss any complaints, learning or best practice. These was no set agenda on the patient safety checklist to prompt these discussions, albeit that the checklist for some wards included an “any other business” section.

Staff could give examples of where learning from incidents had taken place. For example, staff on ward 20 spoke about an incident involving a medical medicines discrepancy. Staff told us that the issue was investigated with audits carried out to check staff were complying with medicines reconciliation process. However, as per the above “Medicines” section, we found between April 2018 and May 2019, staff were not meeting the target for ensuring patients had their medicines reconciled.

We saw evidence of a patient safety incident, and learning, on display in a staff room in ward 18. There was no date for the review, but the incident occurred in 2017. We were therefore not assured that learning from more recent incidents was being consistently shared throughout all surgical staff.

However, the trust sent us information relating to a weekly bulletin called Learning from Incidents. This was specific to the surgical division and highlighted the number of incidents within the wards, theatres and recovery areas. The aim of the document was to summarise an incident or complaint and share learning throughout the division. We saw evidence of a medicines incident being highlighted, as well as an incident relating to the MRI scan of an incorrect patient. There was a learning section on the document, and links to relevant policies for staff to read.

We saw evidence that patient safety alerts being displayed in staffrooms. For example, ward 18 displayed the safety alert relating to the Risk of harm from inappropriate placement of pulse oximeter probes.

Incidents were discussed at a trust wide “harms panel” held every six weeks.

The colorectal ward had a number of incidents relating to Clostridium difficile. Because of this increase in the number of incidents at the beginning of the year, the division carried out a ward audit to ascertain what issues might be contributory factors. An audit was carried out that showed that most staff were complying with hand hygiene techniques, that there were some environmental issues such as skirting coming away from the wall, damaged furniture and clutter in the storage areas. Actions were put in place including daily monitoring, by the ward sister, of patients with diarrhoea to ensure staff followed the diarrhoea pathway, random swabbing of equipment to check for bacteria, and Clostridium difficile positive patients to be transferred immediately to a separate ward. Data showed that there was a downward trend for the number of patients developing Clostridium difficile.

**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 July 2018 to June 2019, the trust did not report any never events for surgery.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

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

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic incident including delay (including failure to act on test results)</td>
<td>6</td>
<td>75.0%</td>
</tr>
<tr>
<td>Treatment delay</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

**Safety thermometer**

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

Safety thermometer data was displayed on wards for staff and patients to see (the information highlighted data from the previous month). This displayed information about compliments and complaints, falls, pressure ulcers, clostridium difficile, E.coli and meticillin-resistant Staphylococcus aureus infections and Friends and Family Test scores.

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 22 new pressure ulcers, 11 falls with harm and 12 new catheter urinary tract infections from May 2018 to May 2019 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Wirral University Teaching Hospital NHS Foundation Trust**

1. Total Pressure ulcers (22)
2. Total Falls (11)
Evidence-based care and treatment

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

The service had designed a number of clinical pathways including an enhance recovery and neck of femur pathway. These pathways were comprehensive and gave clear guidance for staff to follow. We reviewed two patient neck of femur pathways and saw they had been appropriately completed.

The colorectal ward arranged a number of clinics for patients awaiting stoma reversal procedures. This helped to prevent their deterioration in the community.

The division had a designated theatre for emergency surgery, and a designated theatre for trauma surgery. These theatres were staffed as per the Royal College of Surgeons, and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.

Any implants used during surgery were recorded on the electronic patient record and in hard copy notes to comply with traceability requirements.

However, as per the AAGBI guidelines, there was no designated consultant of the day anaesthetist (a supernumerary post) who could offer help and advice. Staff told us that one of the theatres usually doubled their anaesthetist requirements, so someone was available if required.

Anaesthetists checked the equipment themselves, prepared, and labelled drugs.

Safety netting advice was given to patients having surgery, especially around the possibility of developing blood clots. For example, the trust’s website provided details of the complications of surgery, including blood clots, and how weight management could help mitigate these. The service had a comprehensive venous thromboembolism algorithm for nurses to follow during pre-operative assessments.

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, relevant guidance such as the National Institute for Health and Care Excellence.

The theatre recovery area was equipped in accordance with AAGBI guidelines with oxygen, suction, CO2 monitoring and non-invasive blood pressure monitoring. It was staffed in accordance with the British Anaesthetic and Recovery Nurse Association guidelines.

The service had a detailed end to end pathway for neck of femur patients tracking them from admission through to discharge. This was a pathway on the patient’s electronic record that was triggered if they presented at hospital with hip pain.
Some of the wards we visited contained information on notice boards about sepsis, how to spot it, a pathway for staff to follow and reference to Sepsis Six.

The trust used an early warning score system that was in accordance with National Institute for Health and Care Excellence Guidelines 50 - Acutely ill adults in hospital: recognising and responding to deterioration (2007).

The service produced *You and your anaesthetic – information to help patients prepare for an anaesthetic*. This was produced in accordance with the Royal College of Anaesthetists, and the Association of Anaesthetists of Great Britain and Ireland. The leaflet provided detailed information on, amongst other things, the side-effects of anaesthesia and how common they were.

However, there were no staff boards outside each operating theatre as recommended by the Association for Peri-Operative Practice, so it was difficult to easily identify which staff were in which theatre.

**Nutrition and hydration**

*Staff did not fully and accurately assess patients’ nutrition and hydration needs when required. Staff used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.*

The service used a malnutrition universal screening tool to assess patient’s nutritional requirements. The electronic system prompted staff to complete these and performance was also monitored on the surgery performance dashboard. However, the dashboard showed that staff were not regularly completing the nutritional or hydration assessments when they should. Between April 2018 and May 2019, staff only met the target (95%) once. On all other occasions, compliance varied between 93% and 50%. The data suggested that there was a slight upward trend in compliance with the nutritional and hydration assessment requirements.

Patients were asked about their post-operation nausea and vomiting. The colorectal enhanced recovery pathway post-operative care plan included prompts to administer anti-nausea medication if indicated. There were regular nursing prompts to check for nausea and vomiting.

The service had an up to date *Nil by Mouth* policy that set out the fasting requirements for patients due to have surgery. This stated that “adults surgical patients that are nil by mouth should be fasted with food and milky drinks 6 hours pre-operatively”.

Staff on the colorectal ward had good access to the nutritional support team. The recent change of ward location meant that there was sufficient space to relocate the nutrition service to be based within the same ward (although there was no date scheduled for this move).

Patients had a choice of food from a menu. This included hot food and snacks. Halal and Kosher food was available. There was a selection of gluten free foods, low salt and foods specifically for renal patients. The menu advised patients to speak to ward staff if they were unsure of their dietary requirements. Most patients we spoke with liked the food.

Colorectal patients were given a list of food to avoid pre-surgery.

There was a dedicated patient snack fridge in the colorectal ward.

We observed staff offering patients drinks and snacks outside of normal meal times.

Nutrition status boards were displayed in each ward indicating whether, for example, a patient was nil by mouth, required help with eating, or had a diabetic diet. During one of the safety huddles, staff were reminded to check the nutrition board and ensure it was up to date.
The service operated a red tray initiative to clear highlight which patients needed help with feeding.

**Pain relief**

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

Staff assessed pain on a scale of zero to three. Some wards also had picture book for those patients that had difficulty communicating. Staff told us that even if a patient could not communicate, they would look at other signs of pain, such as agitation. The patients we spoke with told us that staff had assessed their pain, provided adequate pain relief, and had returned to check its effectiveness.

Staff had access to a dedicated pain team (provided by the anaesthetic department). Staff told us that if a patient came to the ward from theatres with patient controlled analgesia in place, the pain team would discuss the patient’s requirements with ward staff. Staff also said they could referral patients to the pain team.

The division’s You and your anaesthetic – information to help patients prepare for an anaesthetic leaflet gave advice to patients about local and regional anaesthetics. It also provided advice on different types of post-surgery pain relief including injections, regional blocks and patient controlled analgesia.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment and participated in relevant national clinical audits. However, outcomes for patients were not always positive, consistent or met expectations, such as national standards.**

The service had a higher than expected risk of readmission for elective admissions when compared to the national average. This was particularly relevant to the ear, nose and throat, and urology patients. Colorectal patients, and most non-elective patients, had a lower than expected risk of readmission.

The service met some, but not all of the standards for the National Emergency Laparotomy Audit, and the National Joint Registry Audit. But again, it was performing in a similar range as other organisations.

The bowel cancer audit showed that patients’ length of stays was longer than the national average, but in all other aspects, it was performing in the expected range.

The service had set up the Wirral Acute Fracture Femur Unit approximately two years ago to manage patients with fractured neck of femur to help improve outcomes. This was an eight bedded unit located on an orthopaedic ward. All patients were cared for under the neck of femur pathway, had input from an orthogeriatrician and had physiotherapy input (over 97% of patients were being reviewed by an orthogeriatrician). Patients were encouraged to mobilise on the first day after their surgery. The aim of the unit was to medically optimise patients before stepping them down to a general orthopaedic ward. However, whilst the service was acting similar to other organisation when measured in the hip fracture audit, it had only met one of the four national standards that had been set. Importantly, only 77% of patients were having surgery either on the day of, or the day after admission.

With regard to patient reported outcomes, in 2016 to 2017, the trust performed worse than the England average for groin hernias and varicose veins, slightly worse for knee replacement, and
about the same for hip replacements. However, we only had data from 2016 to 2017 so could not comment on the current position.

During the July 2019 divisional clinical governance meeting, there were discussions around the need to discuss the actions plans required for the National Bowel Cancer Audit, National Oesophago-Gastric Audit, and National Prostate audits. The minutes from the September 2019 meeting showed that the completed plans for the above audits were discussed, with various recommendations put forward. For example, the division noted that a significant proportion of oesophago-gastric cancers were being diagnosed only after an emergency admission. A CQC outlier report also highlighted this. The division stated that it would "look into further and audit" with a response deadline of 31 March 2020.

The division was involved in the “end PJ paralysis” initiative to try to get patients out of bed, dressed and moving. Patients who remain in bed lose muscle strength and can develop pressure areas and ulcers, they can also lose the ability to carry out routine daily functions such as washing and dressing, and this can lead to loss of independence.

**Relative risk of readmission**

**Trust level**

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

- Urology, colorectal surgery, trauma and orthopaedics patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

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

All patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery and urology patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a slightly lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Non-Elective Admissions – Trust Level**

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

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

Arrowe Park Hospital

From February 2018 to January 2019, all patients at Arrowe Park Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

- Colorectal surgery patients at Arrowe Park Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at Arrowe Park Hospital had a much higher than expected risk of readmission for elective admissions when compared to the England average.
- Ear, nose and throat (ENT) patients at Arrowe Park Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - Arrowe Park Hospital

All patients at Arrowe Park Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery and urology patients at Arrowe Park Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Arrowe Park Hospital had a slightly lower than expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - Arrowe Park Hospital

(Source: Hospital Episode Statistics)

National Hip Fracture Database

Arrowe Park Hospital
The table below summarises Arrowe Park Hospital’s performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, ‘similar’ means that the trust’s performance fell within the middle 50% of results nationally.

<table>
<thead>
<tr>
<th>Metrics (Audit indicators)</th>
<th>Hospital performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case ascertainment (Proportion of eligible cases included in the audit)</strong></td>
<td>107.6%</td>
<td>Better</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Crude proportion of patients having surgery on the day or day after admission</strong> (It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)</td>
<td>77.9%</td>
<td>Similar</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Crude peri-operative medical assessment rate (NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)</strong></td>
<td>97.3%</td>
<td>Better</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Crude proportion of patients documented as not developing a pressure ulcer</strong> (Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient’s admission); this measures an organisation’s ability to report ‘documented as no pressure ulcer’ for a patient</td>
<td>96.9%</td>
<td>Similar</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Crude overall hospital length of stay</strong> (A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)</td>
<td>21.2 days</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td><strong>Risk-adjusted 30-day mortality rate</strong> (Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td>8.8%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

**Bowel Cancer Audit**

The table below summarises Wirral University Teaching Hospital NHS Foundation Trust performance in the 2018 National Bowel Cancer Audit.

Case ascertainment is over 100% there are a number of reasons this has occurred including; coding errors in HES, some patients may be referred to other centres for their initial treatment, patient deaths with colorectal cancer from unrelated causes, HES only captures the patients diagnosed with colorectal cancer who are admitted to hospital. Overall nationally, this is done well but variation in accuracy between hospitals may affect their individual results.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Case ascertainment

(Proportion of eligible cases included in the audit)

<table>
<thead>
<tr>
<th>Trusts</th>
<th>Good is over 80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>116.8%</td>
<td>Good</td>
</tr>
</tbody>
</table>

### Risk-adjusted post-operative length of stay >5 days after major resection

(A prolonged length of stay can pose risks to patients)

<table>
<thead>
<tr>
<th>Trusts</th>
<th>Worse than national aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>67.0%</td>
<td></td>
</tr>
</tbody>
</table>

### Risk-adjusted 90-day post-operative mortality rate

(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure)

<table>
<thead>
<tr>
<th>Trusts</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2%</td>
<td></td>
</tr>
</tbody>
</table>

### Risk-adjusted 2-year post-operative mortality rate

(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)

<table>
<thead>
<tr>
<th>Trusts</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.9%</td>
<td></td>
</tr>
</tbody>
</table>

### Risk-adjusted 30-day unplanned readmission rate

(A potential risk for early/inappropriate discharge is the need for unplanned readmission)

<table>
<thead>
<tr>
<th>Trusts</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2%</td>
<td></td>
</tr>
</tbody>
</table>

### Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection

(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)

<table>
<thead>
<tr>
<th>Trusts</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>49.8%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Bowel Cancer Audit)

### National Oesophago-gastric Cancer Audit

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

The table below summarises Wirral University Teaching Hospital NHS Foundation Trust performance in the 2018 National Oesophago-gastric Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trust-level metrics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Case ascertainment</strong></td>
<td>&gt;90.0%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td><strong>Age and sex adjusted proportion of patients diagnosed after an emergency admission</strong></td>
<td>21.2%</td>
<td>Worse</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation.

<table>
<thead>
<tr>
<th>Risk adjusted 90-day post-operative mortality rate</th>
<th>Not eligible</th>
<th>N/A</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Proportion of patients who die within 90 days of their operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Cancer Alliance level metrics
(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.)

| Crude proportion of patients treated with curative intent in the Cancer Alliance | 40.0% | Similar | No current standard |
| (Proportion of patients receiving treatment intended to cure their cancer) |

(Source: National Oesophago-Gastric Cancer Audit)

National Emergency Laparotomy Audit

Arrowe Park Hospital

The table below summarises Arrowe Park Hospital performance in the December 2016 to November 2017 National Emergency Laparotomy Audit. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard.)

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment</td>
<td>100%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>(Proportion of eligible cases included in the audit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of cases with pre-operative documentation of risk of death</td>
<td>78%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of cases with access to theatres within clinically appropriate time frames</td>
<td>83%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>(Proportion of patients who were operated on within recommended times)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre</td>
<td>96%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>(Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of highest-risk cases</td>
<td>84%</td>
<td>Green</td>
<td>Met</td>
</tr>
</tbody>
</table>

Page 162
(greater than 10% predicted mortality) admitted to critical care post-operatively (Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)

Risk-adjusted 30-day mortality rate (Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>100.0%</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted posterior capsule rupture rate (Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.)</td>
<td>0.7%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk adjusted visual acuity loss (The most important outcome following cataract surgery is the clarity of vision)</td>
<td>Not available</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Ophthalmology Database Audit)

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The table below summarises Wirral University Teaching Hospital NHS Foundation Trust performance in the 2018 National Ophthalmology Database Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (hips, knees, ankles and elbows) (Proportion of eligible cases within the trust that were submitted to the audit)</td>
<td>100.0%</td>
<td>Better</td>
<td>Met</td>
</tr>
<tr>
<td>Proportion of patients consented to have personal details included (hips, knees, ankles and elbows) (Patient details help ‘track and trace’)</td>
<td>93.2%</td>
<td>Similar</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>

(Source: National Ophthalmology Database Audit)

National Joint Registry

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

The table below summarises Arrowe Park Hospital performance in the 2018 National Joint Registry.
prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register.

<table>
<thead>
<tr>
<th>Hospital level: Hips</th>
<th>Risk-adjusted 5 year revision ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who need their hip replacement ‘re-doing’)</th>
<th>1.0</th>
<th>Within expected range</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who die within 90 days of their operation)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>Hospital level: Knees</td>
<td>Risk-adjusted 5 year revision ratio (for knees excluding tumours) (Proportion of patients who need their knee replacement ‘re-doing’)</td>
<td>0.5</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td></td>
<td>Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) (Proportion of patients who die within 90 days of their operation)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
</tbody>
</table>

(Source: National Joint Registry)

**National Prostate Cancer Audit**

The table below summarises Wirral University Teaching Hospital NHS Foundation Trust performance in the 2018 National Prostate Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men with complete information to determine disease status (This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)</td>
<td>92.3%</td>
<td>N/A</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy (A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)</td>
<td>5.8%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy (Complications following surgery may reflect</td>
<td>3.9%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy
(External beam radiotherapy uses high-energy beams to destroy cancer cells)

<table>
<thead>
<tr>
<th>Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>No data available</td>
</tr>
<tr>
<td>N/A</td>
</tr>
<tr>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Prostate Cancer Audit)

Patient Reported Outcome Measures

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

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

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

Visual analogue scale (EQ-VAS)

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

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

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.
In 2016/17 performance on groin hernias for both EQ VAS and EQ-5D-5L were worse than the England average. For hip replacements, performance was about the same as the England average for all three measures. For knee replacements for both EQ VAS and EQ-5D-5L were slightly worse than the England average. For varicose veins, performance was worse as the England average for all three measures.

(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

We reviewed the clinical support worker competency file within Ward 18. We saw that staff were signed off for competencies including hand washing techniques. The file included data up to October 2018 when the reviews moved to the electronic system.

The division was due to start a new initiative to help improve staff competencies, including mentoring skills. This involved third year students working with second year students to manage a bay within a unit (staff would be supervised during this time). The purpose of the project was to help promote accountability and provide the skills to become a staff nurse. The initiative was set up with support from the trust’s practice educator facilitators. Ward 18 and Ward 38 (a medical ward) were trialling the project for three months.

Student nurses were allocated a mentor. One of the students told us that they had been “very well looked after”.

Newly qualified nurses had a formal induction programme including a three day trust induction to complete mandatory training, and a four day development programme specific to the role and ward which looked at specific clinical skills. New starters were supernummary for four weeks.

One member of staff told us that they had been supported to attended development courses and had become a clinical support worker champion.

All new theatre staff underwent a period of preceptorship. There was a competency framework book for staff to complete – this book was being updated at the time of the inspection. Newly qualified operating department practitioners were supported for the first six to eight weeks of starting. Staff were encouraged to undertaken further study in anaesthetics or scrub practices via an affiliated university course (six to eight month course).

There were six surgical first assistance (a role undertaken by the registered practitioner who provides continuous, competent and dedicated surgical assistance to the operating surgeon throughout the surgery). These staff had completed the relevant training, including that provided by the Association for Peri-Operative Practice.

We saw evidence that theatre staff had attended simulation training

The division’s performance dashboard showed that, on average almost 85% of staff had had their appraisal (against a target of 88%).

Appraisal rates

Trust level
From April 2018 to March 2019, 90.9% of required staff in surgery received an appraisal compared to the trust target of 88.0%.

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Scientists</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>109</td>
<td>112</td>
<td>97.3%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>35</td>
<td>36</td>
<td>97.2%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>316</td>
<td>350</td>
<td>90.3%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>219</td>
<td>244</td>
<td>89.8%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>98</td>
<td>111</td>
<td>88.3%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>56</td>
<td>64</td>
<td>87.5%</td>
<td>88.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Multidisciplinary working

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

Staff on ward 14 (colorectal) told us that there were regular weekly meetings with the matron, colorectal nurses, specialist nurses, colorectal consultant, theatre assistant and stoma nurses. These meetings did not have a set agenda, and minutes were not taken. However, the team told us that they routinely discussed mortality cases, any problems on the ward, upcoming theatres lists and whether there was sufficient staff cover. They also discussed stoma care and the enhanced recovery programme.

Each neck of femur patient was discussed at a weekly multidisciplinary team meeting with input from an orthogeriatrician, physiotherapy team and nursing team. There was also a daily high level multidisciplinary meeting between physiotherapists, nurses and occupational therapists on the orthopaedic wards.

Ward 10 held a daily meeting between nursing staff, occupational therapists and physiotherapists, which we attended. Each patient was discussed, including discharge planning and therapy sessions. There were discussions about the mobilisation of each patient and what the home and social situation was. Staff discussed what adjustments could be made to patients’ homes to help the discharge process.

There was a regular urology cancer steering group meeting. There were detailed discussions about various projects including the remote monitoring of prostate patients, a community wellbeing project, virtual clinics and patient experience. The meeting held in September 2019 included discussions about a trial without catheter lounge which was planned to be “introduced shortly”. The aim of the project was to free up inpatient beds earlier to accommodate new inpatients.

We saw evidence, in patient records, of involvement from the integrated discharge team to help plan patient discharges.
The ward pharmacist completed a daily ward round for those patients requiring total parenteral nutrition.

The electronic patient records we reviewed showed evidence of multidisciplinary input in their care. One patient had input from the pharmacy team, physiotherapist, occupation therapist and a specialist nurse.

**Seven-day services**

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

The division had 24 hour access to some diagnostic services including X-ray, CT scans and MRI scans. Although staff on ward 10 told us that it could be difficult to obtain diagnostic imaging over the weekend. We saw evidence in the monthly clinical governance meetings about the “pending risk” of the “lack of radiology support to emergency, elective and trauma lists about 5pm and weekends”

Theatres, including anaesthetics and recovery, had staff on call to cover for emergencies.

Staff had access to the mental health liaison service 24 hours a day, seven days a week.

The physiotherapy teams and pharmacy teams primarily worked Monday to Friday. However, they did have on-call arrangements for out of hours and at weekends.

There was a dedicated emergency theatre available 24 hours a day.

**Health promotion**

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

Some information was provided to patients during pre-operative assessments about how they could improve their health to increase the chance of successful surgery and recovery. Wards also contained some patient information leaflets about such things as Clostridium difficile, meticillin-resistant Staphylococcus aureus and infection control.

The trust’s website had a section dedicated to “Improving your fitness for surgery”. There were various sections relating to diet, exercise, smoking and alcohol intake. There was also a short video that patients could watch.

However, there was minimal health promotion information available to patients or visitors on the wards. For example, none of the patient and family rooms on any of the surgical wards displayed any health promotion information. This was a missed opportunity for the service to provide details of such things as health clinics they operated, community schemes or additional support patients, carers and visitors could access.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, staff did not always complete Deprivation of Liberty Safeguards documentation appropriately.**

Staff we spoke with understood mental capacity and could provide examples of where they had had to consider this in the past. This included staff in the pre-operative assessment unit who had had cause to refer a patient back to a consultant for a further capacity review as they did not understand the surgical procedure they had been listed for. Staff also spoke about a patient with post-surgery delirium who had fluctuating capacity during their admission with staff took account of.
Staff we spoke with could articulate what Deprivation of Liberty Safeguards were, and the process for completing an application was straightforward. Staff we spoke with told us that they would always consider the least restrictive option for a patient when considering a Deprivation of Liberty Safeguards application.

The staff room in Ward 18 had an “alert board” displaying various information. This included information about the Deprivation of Liberty Safeguards – what they were and what the process was.

We reviewed three Deprivation of Liberty Safeguard applications. These had been completed appropriately, with evidence of capacity assessments having been completed, and submitted to the relevant service.

However, the division conducted audits of its Deprivation of Liberty Safeguards applications which showed that there had been inconsistencies in how applications had been made. For example, for the audit question “Has the [Deprivation of Liberty Safeguards] application been discussed … and documented in the patients best interest documentation in [the patient record]?”, ward 10 scored 0%, and ward 11 scored 67% in July 2019. The trust told us that these audits had “enabled the safeguarding practitioners to direct bespoke training to frontline [staff] for improvement”. We have not seen the most recent audit results, so we cannot be assured whether improvements had been made.

The records we reviewed provided evidence that consent had been appropriately recorded. We saw evidence that a do not attempt cardio-pulmonary resuscitation order had been completed properly will full involvement with the patient.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Patients said staff treated them well and with kindness.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey (a measure of the percentage that would recommend the service). The scores were positive for all wards. All the patients we met spoke highly of the care provided by nursing and medical staff.

All the patients we spoke with were complimentary about the care they had received from both nursing and medical staff. They told us that staff had spoken with them politely and always took their time, even though they knew they were busy. Most patients told us that staff explained things to them clearly, although one person told us that they did not understand everything that was said (albeit that they said the care they had received was good).

In line with the “Hello my name is …” campaign, we observed both nursing and medical staff introduce themselves by name.

The previous month’s Friends and Family Test performance was displayed on the entrance to each ward.

Whilst electronic boards in the surgical wards contained patient names, these were minimised when not in use to protect their privacy.

We observed nurses knocking on patients’ doors before entering, and the patients we spoke with told us that staff respected their privacy and dignity.

The service could arrange chaperones for any patients if required.
Notice boards on the entrance to wards displayed a “You told us” section that highlighted comments from patients. One of these stated that the “quality of treatment from surgery to ward nursing staff is absolutely exemplary.”

**Friends and Family test performance**

From June 2018 to May 2019, the Friends and Family Test response rate for surgery at the trust was 20%, which was lower than the England average of 24%.

The table below shows the response rate by site:

<table>
<thead>
<tr>
<th>Location/site</th>
<th>Number of responses</th>
<th>Response rate</th>
<th>Annual performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrowe Park Hospital</td>
<td>1831</td>
<td>24%</td>
<td>97%</td>
</tr>
<tr>
<td>Clatterbridge Hospital</td>
<td>882</td>
<td>15%</td>
<td>99%</td>
</tr>
<tr>
<td>Total</td>
<td>13761</td>
<td>20%</td>
<td>97%</td>
</tr>
</tbody>
</table>

4. 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), as well as wards where there were less than 100 responses in total over the 12 month period.

5. Sorted by total response.

6. 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.

From June 2018 to May 2019:

- Annual performance for all wards was between 95%-100%
- SDCU (general surgery) had the lowest response rate (17%), which it accounted for 23.3% of all responses across the surgical wards.
- Ward M2 (general surgery/trauma and orthopaedics) had the highest response rate (76%), which it accounted for 18.2% of all responses across the surgical wards.
- Ward 17 (general surgery) scored the highest, with 100% patients recommending the service in 10 months of the year.
- The lowest annual percentage recommended was for SDCU (general surgery), with recommendations overall of 95%.

(Source: NHS England Friends and Family Test)

**Emotional support**

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

The housekeeper on the colorectal ward had been a hair dresser, and they cut and washed the hair of patients that had spent a long time in hospital. Staff told us that they understand the impact of long stays on patients’ and this helped to improve their wellbeing.
Staff demonstrated they understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives.

All the patients we spoke with told us that staff took time to discuss their condition and made sure they understood what would happen.

One patient told us that staff had been “so calm” and had helped them “get over their moods”

There were boards behind patient beds on the wards that included a “This is me” section. We saw that this had been completed for a number of patients, including a patient who put down their tea and coffee preferences.

We were told of examples where staff had gone above and beyond to provide support to patients and their relatives. Staff described an example of organising a ceremony for a patient who had a terminal illness.

One patient told us that they staff had arranged for a chaplain to visit them to meet their religious needs as they could not attend the chapel due to their condition.

**Understanding and involvement of patients and those close to them**

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

Patients we spoke with said that staff talked with them in a way they could understand. Patients told us that staff members also kept their families and carers updated as needed and took time to explain information to them.

Staff on the surgical assessment unit had developed small cards for visitors which they could present to staff if they were visiting after hours. These cards “allowed” the visitors to visit outside of normal hours and helped to better involved them in the care of those close to them.

One of the patients we spoke with said that staff had involved their daughter in their care and made sure they understood what was happening and why.

We saw evidence, in the records we reviewed, of discussions with family members.

We heard examples of where staff had arranged birthday parties for patients, with family in attendance.

**Is the service responsive?**

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

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

There was some evidence of work with local commissioners and other health service providers to review and meet the needs of local people. For example, the trust had worked with the local clinical commissioning group and other health partners to develop an integrated musculoskeletal triage service for Wirral. The aim of the service was to provide “patients with timely assessment and management of musculoskeletal conditions, including community based access to key services such as physiotherapy, pain, rheumatology and podiatry, along with elective orthopaedic surgery”.

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The service had developed a *Coming into Hospital – Information Leaflet*. This included information about how patients could ensure they were fit for surgery and things they would need to arrange prior to admission. It also included relevant contact numbers, visiting hours and directions to the hospital, including websites for public transport companies.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Most wards had electronic patient boards that could highlight individual needs of some patients – for example those living with dementia. This was done discreetly using symbols.

There was a multi-faith area at the hospital which patients, visitors and staff could use. The hospital could arrange communion, and the prayer rooms were available for Muslim Friday Prayers. The multi-faith areas had religious texts available. There was a chaplaincy service for patients, visitors and staff could access (they were also available for urgent requests out of hours).

Whilst there were day rooms for patients and visitors on some of the surgical wards, these were sparsely decorated and with no health related information available to read.

There were a number of free parking spaces for patients and visitors.

**Meeting people’s individual needs**

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

The colorectal team had produced a patient diary which allowed patients to comment on the standard of care they had received.

Staff on the surgical assessment unit told us that they could use arm sleeves to help distract patients living with dementia whilst they were providing care. Patients could also be given other equipment to help with distraction. Staff told us that whilst there were set visiting hours, these were often relaxed for the families and carers of those patients living with dementia, or who had autism or a learning disability.

The surgical assessment unit had developed some small laminated cards for visitors and carers. These cards highlighted that the carer could visit outside of normal visiting hours.

The service had access to interpreter services, including sign language.

The service adhered to the accessible information standard. For example, there were prompts on the electronic pre-operative assessment pathway for staff to ask whether the patient had any hearing or sight difficulties, what their communication needs were, and how they would like to be given information (for example, in braille).

The trust's website could be configured to increase the text size, change the language (there were 28 languages to choose from) and adjust the contrast of the text.

Staff had access to dementia champion within the trust for advice.

The trust had also developed a dementia strategy which aimed to help patients living with dementia maintain their independence as long as possible.

The service operated the dementia “forget me not” scheme; a symbol used to help identify patients living with dementia.
There was individualised care planning for patients living with dementia including a This is Me document.

Over the course of the inspection we observed staff taking time to support patients with dementia, including accompanying them when they were walking around the ward area. Staff took their time with the patient and did not rush them.

Staff told us about working with the carers of a patient with a learning disability. They ensured that funding was in place to allow the carers to spend additional time with the patients whilst they were in hospital.

A poster on entrance to Ward 18 provided information about the Dementia Café held every Thursday afternoon. It also provided contact details for the dementia nurse and dementia matron.

Staff in the pre-operative assessment clinic told us about a patient who was always agitated when they came to the hospital. They arranged for a pre-operative assessment to be carried out by telephone and liaised with community staff for the patient to have a sedative prior to arriving in hospital for surgery. Staff also told us of letting patients play with computer games during assessments to help keep them calm.

However, there were no obvious ways in which the wards had been more dementia friendly – for example, different coloured bays or dementia friendly clocks. However, we noted that the care provided for patients living with dementia was appropriate.

We saw staff making reasonable adjustments, including communicating with a patient using a white board as they could not verbalise.

One patient told us that a doctor worked with them to make sure that the time of their surgery worked best around their work commitments and that the doctor had been “superb” in this regard.

The hospital had a dedicated Learning Disability and Autism Team who, amongst other things, could provide support for patients accessing planned care, such as surgical procedures.

The trust’s website highlighted that it was “committed to raising awareness of reasonable adjustments” for people with learning disabilities and to act in accordance with the Equality Act (2010). The website contained a link to a short video explaining what reasonable adjustments were for people with learning disabilities.

Patients were given a choice of food and drink to meet their cultural and religious preferences. This included hot food and snacks, with Halal and Kosher food was available.

**Access and flow**

People could not access the service when they needed it and or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national expectations for a number of specialities.

Managers and staff worked did not always ensure that patients did not stay longer than they needed to.

The number of cancelled operations were not kept to a minimum, and they were not rearranged as soon as possible and within national targets and guidance.

Access and flow was an issue for the division. There was a large number of medical outliers in surgical wards. For example, whilst the surgical assessment unit could hold 40 surgical patients, over a quarter of beds contained medical patients during our time on site.
Some surgical patients stayed in hospital in line with the England average. However, both elective and non-elective trauma and orthopaedic patients stayed in hospital longer than the England average.

There were a high number of cancelled operations at the hospital, and a high percentage of these were not treated within 28 days. In the last three months of 2017 to 2018, there were 59 cancelled operations, 63% of which were not rescheduled within 28 days. From the end of that period to quarter three 2019 to 2019, the trust's performance improved but still remained worse than the England average. In the final quarter of 2018 to 2019, there was a decline in performance again with 33 cancellations, 30% of which were not treated within 28 days (worse than the England average).

The division was also not treating patients within the agreed national target of 18 weeks. The division was not meeting the national target for six specialities including general surgery (57%), trauma and orthopaedics (45%) and oral surgery (22%). The service acknowledged that it had issues with referral to treatment times and had been tracking these to ensure that those patients waiting the longest time were prioritised. Whilst this had led to a reduction in those patients waiting over 52 weeks for surgery (there had been no breaches since April 2019), there had been limited progress towards the 18 week target.

There was a worsening picture for stranded patients. Whilst there had been 63 stranded patients in June 2018, this had increased to 91 in May 2019.

The service had introduced a 10 by 10 scheme in March 2019 – a process whereby each surgical ward would aim to discharge two patients by 10am each day (across five surgical wards). The scheme aimed to use a number of initiatives to help discharge including matrons conducting daily board rounds to support discharge planning, and ward based medical cover to try and ensure take home medications were prescribed and dispensed the day before discharge. However, staff told us that there was still an issue with ensuring patients received their take home medication in a timely manner. Whilst doctors were signing off patients as being medically fit for discharge during the morning ward round, they were unable to write to discharge letter until after surgery in the afternoon. As patients could not be given their take home medication and discharged without the discharge letter, there were often delays in patients going home. The division had a target of at least 33% of discharges taking place before 12pm. Despite the initiatives in place, the performance dashboard showed that only 17% of discharges took place before noon.

We observed patients arriving in recovery with no bed space available for them. This was mainly due to delayed discharges from the ward meaning that there were no beds readily available. We spoke with one patient (on a trolley) who had been waiting three hours for a ward bed.

Whilst some wards had dedicated clinics to see patients after discharge to ensure that they were recovering well, this was not universal. For example, the general surgery ward (ward 18) said that outside of normal follow-up outpatient appointments, patients would have to be referred back to the service for any additional medical care.

The surgical elective admissions lounge had planned to introduce a three stage recovery unit in early 2020, with financial approval already signed off. This aimed to help reduce the number of day care patients requiring a hospital bed.

Pre-operative staff told us that there were no streaming initiatives in place to fast track the assessments of patients who were medically and who did not require a full pre-operative assessment.

Ward 11 had a regular weekly meeting about delayed discharges. They were attended by allied health professionals, nurses and the integrated discharge team. Staff discussed stranded patients,
which included a review of their requirements including rehabilitation at home and what services they might need. However, staff told us that there were delays in accessing community services with one patient waiting almost two weeks for input.

There was an enhanced recovery team within the colorectal ward to help patients leave hospital sooner following surgery. This team looked to pre-empt issues that might arise from surgery and ensure discharge plans were in place. There were pathways in place to try and prevent readmissions.

**Average length of stay**

**Trust Level – elective patients**

From March 2018 to February 2019 the average length of stay for patients having elective all surgery at the trust was 3.2 days. The average for England was 3.8 days.

- The average length of stay for patients having elective trauma and orthopaedics surgery at the trust was 3.3 days. The average for England was 3.7 days.
- The average length of stay for patients having elective urology surgery at the trust was 2.9 days. The average for England was 2.5 days.
- The average length of stay for patients having elective colorectal surgery at the trust was 5.7 days. The average for England was 7.0 days.

**Elective Average Length of Stay – Trust Level**

![Bar chart showing Elective Average Length of Stay - Trust Level](chart1)

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

**Trust Level – non-elective patients**

The average length of stay for patients having non-elective all surgery at the trust was 4.8 days. The average for England was 4.7 days.

- The average length of stay for patients having non-elective general surgery at the trust was 3.9 days. The average for England was 3.6 days.
- The average length of stay for patients having non-elective trauma and orthopaedics surgery at the trust was 9.8 days. The average for England was 8.4 days.
- The average length of stay for patients having non-elective urology surgery at the trust was 3.0 days. The average for England was 2.7 days.

**Non-Elective Average Length of Stay – Trust Level**

![Bar chart showing Non-Elective Average Length of Stay - Trust Level](chart2)

*Note: Top three specialties for specific trust based on count of activity.*
Arrowe Park Hospital - elective patients

The average length of stay for patients having elective all surgery at Arrowe Park Hospital was 3.8 days. The average for England was 3.8 days.

- The average length of stay for patients having elective urology surgery at Arrowe Park Hospital was 3.1 days. The average for England was 2.5 days.
- The average length of stay for patients having elective trauma and orthopaedics surgery at Arrowe Park Hospital was 5.0 days. The average for England was 3.7 days.
- The average length of stay for patients having elective colorectal surgery at Arrowe Park Hospital was 5.8 days. The average for England was 7.0 days.

**Elective Average Length of Stay - Arrowe Park Hospital**

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

Arrowe Park Hospital - non-elective patients

The average length of stay for patients having non-elective all surgery at Arrowe Park Hospital was 4.8 days. The average for England was 4.7 days.

- The average length of stay for patients having non-elective general surgery at Arrowe Park Hospital was 3.9 days. The average for England was 3.6 days.
- The average length of stay for patients having non-elective trauma and orthopaedics surgery at Arrowe Park Hospital was 9.8 days. The average for England was 8.4 days.
- The average length of stay for patients having non-elective urology surgery at Arrowe Park Hospital was 3.0 days. The average for England was 2.7 days.

**Non-Elective Average Length of Stay - Arrowe Park Hospital**

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

(Source: Hospital Episode Statistics)

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

From June 2018 to May 2019 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was consistently much worse than the England average. The trusts referral to treatment ranged from 50.5% (November 2018) to as low as 22.4% (February 2019) compared to the England average which ranged from 68.3% (December 2018) to 63.3% (March 2019).
Referral to treatment (percentage within 18 weeks) – by specialty

There were no specialities above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Six 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>General Surgery</td>
<td>57.1%</td>
<td>72.0%</td>
</tr>
<tr>
<td>Urology</td>
<td>55.5%</td>
<td>75.3%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>44.5%</td>
<td>58.6%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>41.8%</td>
<td>60.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>37.2%</td>
<td>63.4%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>21.6%</td>
<td>56.1%</td>
</tr>
</tbody>
</table>

Cancelled operations

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

Over the two years, the percentage of cancelled operations at the trust had the largest amount of cancellations (79) in Q3 2017, however only 1% of these weren't treated within 28 days. In the following quarter, Q4 2017/18 there were 59 cancellations, 63% of which weren’t treated within 28 days. From Q4 2017/18 to Q3 2018/19 the trust's performance in cancellations that were treated within 28 days improved but remained worse than the England average. The latest quarter, Q4 2018/19 showed a decline in performance again with 33 cancellations, 30% of which weren’t treated within 28 days, which remained worse than the England average.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Wirral University Teaching Hospital NHS Foundation Trust.
Over the two years, the percentage of cancelled operations at the trust was consistently lower than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Patient moving wards at night

From June 2018 to May 2019, there were 3,448 patient moving wards at night within surgery. Ward 14 had the largest amount of moves at night with a total of 1,313 (38.0%).

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

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

All wards we visited carried leaflets advising patients and relatives how they could complain. The leaflet explained the complaints process and included details of the Parliamentary and Health Service Ombudsman.

We reviewed three completed complaint investigations relating to surgery. In all cases the complaints were acknowledged quickly with the main heads of complaint being agreed. We saw evidence of cross department working and working with other NHS organisations to ensure a
comprehensive response. All three complaints were completed within 30 days with further details given to the complainant about their right approach the Parliamentary and Health Service Ombudsman if they remained dissatisfied.

The patient advice and liaison team visited some of the surgical wards to speak to patients and ask about the care they were receiving. The team aimed to address any issues before they escalated.

All patients we spoke with told us that they would feel comfortable raising a complaint if necessary. However, all these patients were happy with the care they had received and had no cause to complain.

The trust did not provide data at divisional level regarding the timeliness of complaint responses. However, the trust had not met its target for responding to complaints (37.5 days against a target of 30 days).

**Summary of complaints**

**Trust level**

From July 2018 to June 2019 the trust received 60 complaints in relation to surgery at the trust (26.2% of total complaints received by the trust). The trust took an average of 37.5 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be investigated and close complaints within 30 days.

However the trust target for completing complaints prior to December 2018 had been 25, 45 or 60 working days (depending upon complexity).

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>20</td>
<td>33.3%</td>
</tr>
<tr>
<td>Treatment &amp; Procedure</td>
<td>18</td>
<td>30.0%</td>
</tr>
<tr>
<td>Access &amp; Admission</td>
<td>9</td>
<td>15.0%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>6</td>
<td>10.0%</td>
</tr>
<tr>
<td>Transfer &amp; Discharge</td>
<td>4</td>
<td>6.7%</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>1</td>
<td>1.7%</td>
</tr>
<tr>
<td>Documentation</td>
<td>1</td>
<td>1.7%</td>
</tr>
<tr>
<td>Tests &amp; Results</td>
<td>1</td>
<td>1.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</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**

From July 2018 to June 2019 there were 42 compliments about surgery at the trust.

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

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There had been a number of managerial and leadership changes within the division since we last inspected the service. The trust had adopted a triumvirate approach to management of the divisions. Each division consisted of a divisional director of nursing, divisional director and an associate medical director.

The leadership team told us that they took it in turns to conducted ward walk arounds which they said helped get feedback from staff. The majority of the staff we spoke with told us that the matrons and divisional managers were approachable. However, whilst some staff told us that the divisional managers and the trust executive team were visible and had been on the wards, other staff told us that they had not seen them.

We spoke with one of the matrons who was complimentary about the leadership of the division. They told us that the division had been supportive when they had looked to introduce new ideas to improve such things as infection prevention control.

We spoke with some staff members who had had the opportunity to develop their careers at the hospital and were now at a managerial level.

The leadership team gave examples of where they had tried to support underperforming staff to increase their skills. They also acknowledged that underperforming staff also needed to be held to account if poor performance continued.

The trust had a leadership succession programme (“Top Leaders”) which the divisional triumvirate were progressing through. The programme was slowly being cascaded to Band 7 staff and would eventually be offered to Band 6 staff. The team explained that there had been a very hierarchical structure in the division and the leadership programme was an attempt to have leaders at all levels to challenge and promote good practice.

The trust was looking to develop a “shadow board” to allow leaders to have experience of working at executive level and gain experience and knowledge.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, albeit that it had not been fully effective.

The division had a clear strategy that centred on providing high quality safe care for all patients. It planned to achieve this “through the empowerment of our workforce, with clear regular communications and the progressive use of technology and innovation”. The key objectives include patient flow and theatre utilisation. However, we identified that there remained issues with patients being able to access services.

Most of the staff we spoke with were aware that the that the division’s main strategy was to improve patient flow, as well as staffing issues.

We saw evidence of the division’s vision and strategy on display on the wards. For example, a notice board on the entrance to the surgical assessment unit highlighted that it had introduced four emergency surgery consultants within the department to help improve waiting times.

The monthly matrons meeting included discussions about patient flow, A&E admissions, social problems and timely discharges.
We saw that ward 18 displayed the trust’s nursing and midwifery strategy, but this was for 2013-2018 and therefore out of date.

**Culture**

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

There had been a change to a number of managerial positions since our last inspection. New matrons had been recruited, and most of the divisional leadership team had changed.

Most staff told us that there was a good relationship with the divisional managers, with one member of staff describing how a manager came to help with a ward move. A clinical support worker told us that they “loved their job”. We spoke with a student nurse who told us that they enjoyed working at the hospital. They felt that training was good, and they had enjoyed the experience.

Staff we with spoke told us that there were generally good working relationships between nursing and medical staff, and that a positive culture had developed over time.

Most staff we spoke with knew who the Freedom to Speak Up Guardian was. There were also details about how to contact them on the trust’s intranet.

Ward 18 displayed information relating to *Fair Care for Trans Patients – a [Royal College of Nursing] guide for nursing and healthcare professionals*. This was a resource designed to help staff respond to the needs of patients and clients who identified as transgender.

Leadership team explained that in the past there had been “silo” working, which each area focusing on their individual specialities. They explained that they had tried to shift this thinking to one trust working together. They said that there was still work to do but it felt that the message was getting across.

The divisional newsletter included reminders for staff to participate in the “value, behaviour and leadership” sessions it had run.

However, one surgeon we spoke to told us that there was a lack of communication from the division and the executive team about the possible cessation of elective surgery over the winter months to help cope with increase demand of medical patients.

Staff on one of the wards told us that they had had issues with radiology staff, with one consultant saying that they did not want to speak to nursing staff.

**Governance**

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

The division had a clear governance structure. There were regular meetings at ward level which fed directly into the monthly divisional triumvirate meeting (this meeting also included a review of the risk register). There was a monthly surgical directorate business meeting with all surgical specialties represented. These business meeting fed into the surgical clinical governance meeting which in turn reported to divisional clinical governance meeting and the divisional management team meeting.

The ward matrons met with the divisional leadership team monthly. The pre-set agendas included discussions about the infection prevention control assurance plan, falls update, perfect ward data,
domestic violence and updates from the deputy director of nursing. Those staff that could not attend were sent a “Sorry you missed it” briefing document which included details of what was discussed. The document for the July 2019 meeting included information about how the safeguarding team could provide support for domestic violence cases. There were also discussions about new Nursing and Midwifery Council guidelines about prescribing. Updates from the deputy director of nursing included details of the focus on monitoring fluid intake and fluid balance in line with the trust’s new nutrition and hydration workstream.

We reviewed minutes from the divisional clinical governance meetings. There were set agenda items that covered infection control, clinical governance reports and the main issues arising from them (including any incidents and complaints, reviews of any updated guidelines, and any specific risks). There were discussions about local safety standards for invasive procedures, including the need for additional standard operating procedures to be developed. There was also a reminder for staff to read a CQC report relating to pressures in the Emergency Department.

The divisional risk register was also discussed at the divisional clinical governance meeting, with new risks being added once validated and approved (and risk rating above ten was added to the divisional register). We reviewed the risk register which included issues relating to delayed discharge, stranded patients and patient flow. The register contained the risk description, risk lead and control measures in place, along with the date the risk needed to be reviewed.

The performance dashboard was discussed during the governance meetings. The increase in sickness rates was highlighted as an issue, as was the deteriorating compliance rates with nutritional assessment which the matrons were asked to address with ward staff. There was a focus on stranded patients and identifying those that could be discharged. There were discussions surrounding having implementing board round on each ward at 4pm to try and identify next day discharges, albeit that there was no date for when this might be introduced.

Along with the regular divisional workforce assurance meetings that were led by the matrons, there was a trust wide workforce assurance committee which were held monthly. These meetings looked at trust wide issues, but with a focus on individual divisions if specific problems identified. We saw evidence of discussions about recruitment campaigns, staff survey results (and the next steps), and workforce disability and workforce race equality standards.

The workforce assurance committee identified that there were issues with staff training around issues such as the completion of venous thromboembolism assessments (audits between April 2018 and January 2019 showed that compliance with assessments had, at times, dropped to 22%). The committee acknowledged that there was work to do surrounding training needs. Other actions also included ensuring the staff electronic staff record system could monitor compliance with training. Between February 2019 and May 2019, the trust had achieved over 96% compliance with venous thromboembolism assessments.

The divisional workforce committee meeting also reviewed reports setting out whether it was meeting key staffing metrics such as vacancy rates, completion of core mandatory training, and turnover rates.

The division had started to undertake a number of audits that measured an individual ward’s compliance with 14 key measures including patient safety, safeguarding, pressure ulcers, pain and infection control. These audits were carried out on iPads and gave immediate feedback. The results fed into a ward accreditation system with wards rated either red, amber or green.

We saw the audit results for a number of surgical wards. For example, ward 10 had poor compliance with safeguarding processes, organisation and management, and pressure ulcers. It managed falls well, along with pain and patient safety. An improvement schedule was developed in
response to the audit. This included the safeguarding team supporting ward staff with education, increasing checks on mattress to check for damage, and reminding staff about Braden assessments (a tool used to assess to risk of a patient developing a pressure ulcer). It also included reviewing leadership training and improving staff knowledge of Duty of Candour.

A theatre resource group met weekly and looked at theatre planning and retrospective reviews of activity. The group had introduced a three week plan for theatre sessions so enable better planning and had also moved some surgical procedures to another hospital within the trust. The team was eventually looking to move to a ‘6-4-2’ model where surgical staff declared their annual leave six weeks in advance, scheduled surgical lists four weeks in advance, and reviewed plans two weeks in advance.

The leadership team told us that they reviewed all reported serious incidents via a weekly serious incident panel which they attended along with other disciplines throughout the hospital. The panel decided whether an incident met the criteria for a serious incident. Any incident meeting the criteria would undergo a root cause analysis investigation. Any incident not meeting the criteria would still undergo a local review to establish if there was any learning. The leadership team told us that it felt assured that they were cited on all possible serious incidents.

There was a monthly Neck of Femur multidisciplinary team meeting attended by various staff including administrators, consultants, matrons and nursing staff, and physiotherapists. The meeting reviewed various metrics including average time to ward from the emergency department, and percentage of patients undergoing surgery within 36 hours. During the August 2019 meeting, there were discussion relating to best practice, and discussion surrounding the number of neck of femur patients suffering constipation post-surgery and what action could be taken to improve patient experience. The minutes of the meeting in July 2019 highlighted that the previous meetings had not been well attended. All staff were present for the September 2019 meeting.

Neck of Femur multidisciplinary team meeting highlighted that between 20 and 25% of patients did not meet the 36 hour standard between June and August 2019. Staff discussed the reasons for these “fails”, but these were not recorded in the minutes, nor was there any record of what action would be taken to help avoid them in the future.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. Whilst they identified and escalated relevant risks and issues, agreed plans had not reduced their impact and issues identified at the previous inspection were still apparent.

The team had rectified some issues identified at the previous inspection. These included moving the colorectal unit and improving the staffing vacancy situation. However, other issues, such as patients accessing the service, and achieving a timely discharge, had not been addressed.

The team acknowledged that it had issues with referral to treatment times and had been tracking these to ensure that those patients waiting the longest time were prioritised. Whilst this had led to a reduction in those patients waiting over 52 weeks for surgery (there had been no breaches since April 2019), this work had not impacted on the 18 week NHS constitutional standard.

The team was also aware of the issues surrounding the late completion of discharge letters which was affecting discharge times. The division explained that they were working towards a model whereby discharge letters were written the day before the date of discharge, although this had not yet been implemented. It was also looking to move more towards a nurse led discharge. However, the leadership team told us that changes needed to be made to processes and IT systems, so it was unlikely that this would be operational until 2020.
Medical outliers, cancelled operations (and the length of time to reschedule treatment), access to services and timely patient discharged continued to be a problem for the service (as it was during the previous inspection). Whilst we were satisfied that the division understand what its key issues where, we did not see specific plans, including trajectory targets and whether the division was on track, that would help monitor and address these concerns. We were therefore not assured that there would be any significant improvement in these areas in the immediate future.

We saw evidence that division was completing WHO checklist audits, albeit that this information did not appear on the surgery performance dashboard. The checklist audits showed a varying compliance rate of between 78% and 99% (observational audits) between November 2018 and October 2019. During our own observations we found that staff did not introduce themselves on five out of six occasions. We also observed staff not paying attention or arriving after the sign in procedure had started.

The service had undertaken a risk assessment relating to the move of the pre-operative assessment unit to the cardiovascular unit. This identified a number of the issues also raised by staff during our inspection including signage, the size of the rooms and their suitability for patients in wheelchairs, and the lack of a permanent room for the clinical support worker. However, whilst the risk assessment had been completed in June 2019, there was still no appropriate signage in place (the old signage was still in place which caused confusion during the inspection). There was also no consideration given to the risk of patients becoming lost due to the “mobile” clinical support workers room, or the risk of patients wandering due to the lack of visibility of the waiting area from the reception desk.

We attended one bed meeting for the surgery division. There was discussion about medical outliers in the surgical wards and the number of available beds. The integrated discharge team was present to discuss any issues surrounding packages of care in the community. Highlighted priorities including keeping the surgical assessment areas as free as possible and liaising with the emergency department.

The division had developed a surgery performance dashboard that set out whether it was meeting key performance indicators, these included cancelled operations, stranded patients, venous thromboembolism assessments and nutritional assessments. These key indicators were mapped against the CQC’s five key questions about whether a service was safe, effective, caring, responsive and well-led. Each indicator was graded either red, amber or green to provide a clear position on whether targets were being met. It was also clear to establish whether a specific metric was improving or deteriorating.

Public Health England encourage trusts to report surgical site infection data against 17 categories. Four of these (all orthopaedic) are mandatory – there is a requirement to conduct surveillance for at least one orthopaedic category for one period in the financial year. The remaining 13 categories can be reported against on a voluntary basis. The trust provided evidence that it had done this, reporting reduction of long bone fracture and Repair of Neck of Femur in January to March 2019, and hip fracture data for the same period in 2018.

**Information management**

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

The division had developed an electronic portal for urology patients which allowed them to have remote access their own information including certain results and clinic letters. The service could set
delays on when the information could be seen by patients to give clinicians time to speak to them if there was an issue that required further explanation or support. The division was looking to roll the system out to other surgical areas, but further cost to value assessments needed to be carried out before a business case could be put forward.

The service used information from the electronic patient record system to monitor the effectiveness with care standards. For example, we saw that nutrition and hydration assessment data was collected and monitored via the performance dashboard. The data was discussed during various divisional meetings. Theatre utilisation rates and cancelled operation figures were also discussed.

The service submitted data to several national audits that monitored patient outcomes.

Most staff told us that there were sufficient computer terminals to allow them to access patient records and make necessary referrals.

The service used electronic records to manage patient information. We saw that these terminals were locked when not in use.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The colorectal team had produced a patient diary which allowed patients to provide their views and give direct feedback about the care they received. Diaries were reviewed at once a to see how care could be improved. As part of the feedback, the service was looking to reintroduce a specialised colorectal team member to attend pre-operative assessment clinics to help answer specific questions and reduce patient anxiety. The service had also replaced bins on the ward with soft close lids and patients said that the previous ones were noisy and disturb them at night. The team also told us that they were looking to “explore ways to collocate (within bays) patients who had experienced same or similar surgery as patients have reported this peer support was very positive”.

The colorectal team had started to use a new surgical technique to treat patients with large hernias (the insertion of medical gases into the affected area). Staff told us that this technique was relatively unique in the country. A patient who had been successfully treated using the method had agreed to speak to others about the procedure and how it had “changed their life”.

Some staff information was displayed on computer screen savers. We some information relating to the cyber safety month, staff flu jabs, and the staff survey that was due in November 2019.

Staff told us that they were given sufficient communication about the move of the colorectal ward. However, staff on the pre-operative assessment unit told us that whilst there had been some discussions about a possible move, they were only given a week’s notice when the final decision was made.

Staff member had the chance to travel to USA to look at discharge process in other medical facilities.

Leadership team said that they had engaged with patients and listened to feedback. For example, the trust had previously removed hot evening meals from the menu, but these had been reintroduced following feedback. The division had also introduced finger food for patients with cognitive impairment who struggle to manage large portions of food (we saw these options on the menus).

The division had developed a bi-monthly newsletter which included details of new starters, the introduction of new pathways (for example the 10 by 10 patient flow scheme) and upcoming investment in the division (including new medical equipment for theatres).
There was peer working with other NHS organisations in the northwest region, with the ward accreditation scheme adopted from other providers.

**Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services.**

We spoke with a member of staff who was the sepsis lead for the division. They explained that they had liaised with other trusts in the region to introduce a sepsis response (although the business case for this had not been signed off at the time of the inspection).

Staff within the orthopaedic wards could work within the Wirral Acute Femoral Fracture Unit. This provided them which opportunity to improve competencies and patient care in this area.

The leadership team told us that they were working with local GPs to help reduce patient returns to hospital. It was looking at introducing general surgeon hotlines which GPs could access. This would allow them to talk to consultants rather than simply referring patients to the emergency department. This project had not yet been signed off with further consultations with local GPs planned.

The service planned on hosting a Nursing and Midwifery Council conference in October 2019

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**Wirral University Teaching Hospital NHS Foundation Trust**

**Evidence appendix**

Arrowe Park Hospital, Arrowe Park Rd, Birkenhead, Wirral CH49 5PE

Tel: 0151 678 5111
www.wuth.nhs.uk

Date of inspection visit: 8 October to 14 November 2019
Date of publication: 31 March 2020

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.

**Services for children and young people**
Facts and data about this service

Inpatient paediatric care is provided on the children’s ward with 67 beds and a dedicated day case area supports those children requiring surgery within the service or those requiring day care. There is provision for high dependency care on children’s ward.

A paediatric outpatient department with specialist outpatient clinics (which are also provided off the main site within the community setting) offer a range of outpatient services to children. Specialist nurses further support the department and specialise in respiratory conditions including cystic fibrosis, diabetes, epilepsy, ADHD, and allergies. The community paediatric service provides a range of care for children with long term conditions such as educational, neurophysiological, ADHD and Autism.

A continuing care team consists of a range of nurses and support staff provide a range of care packages delivered in the child’s own home until care is transitioned to adult services.

Level 3 Neonatal care is provided to those babies requiring additional specialist care in both an intensive care and high dependency care setting. This is further supported with a transitional care area on the maternity ward.

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

The trust had 6,237 spells from March 2018 to February 2019.

Emergency spells accounted for 97% (6032 spells), 3% (198 spells) were day case spells, and the remaining 0% (7 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from March 2018 to February 2019, Wirral University Teaching Hospital NHS Foundation Trust.

Total number of children’s spells by Site, Wirral University Teaching Hospital NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrowe Park Hospital</td>
<td>6,237</td>
</tr>
<tr>
<td>This trust</td>
<td>6,237</td>
</tr>
<tr>
<td>England total</td>
<td>1,146,418</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)
We carried out an unannounced inspection of the service between 15 and 17 October 2019.

During this time we were told that the service was in a period of change and development having recently appointed a consultant nurse to offer clinical leadership to advanced clinicians as well as several new appointments of key leaders within it.

Throughout our inspection we spoke with seven patients and relatives, a number of medical, nursing and allied health members of staff as well as senior leaders within the department.

We reviewed 13 sets of patient records and a number of policies and procedures

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

Mandatory training
Mandatory training in key skills was available however not all staff had completed it.

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

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>135</td>
<td>142</td>
<td>95.1%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>132</td>
<td>142</td>
<td>93.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>130</td>
<td>142</td>
<td>91.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>CPR</td>
<td>124</td>
<td>142</td>
<td>87.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Level 2</td>
<td>119</td>
<td>142</td>
<td>83.8%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>118</td>
<td>142</td>
<td>83.1%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security Awareness Level 1</td>
<td>113</td>
<td>142</td>
<td>79.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>113</td>
<td>142</td>
<td>79.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>97</td>
<td>142</td>
<td>68.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In children’s services the 95% target was met for one of the 10 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for medical staff in children's services is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Fire Safety Level 1</td>
<td>25</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>22</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>22</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>21</td>
</tr>
<tr>
<td>CPR</td>
<td>20</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>5</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>16</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>15</td>
</tr>
<tr>
<td>Data Security Awareness Level 1</td>
<td>12</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>1</td>
</tr>
</tbody>
</table>

In children’s services the 95% target was not met for any of the 10 mandatory training modules for which medical staff were eligible.

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

Mandatory training modules were comprehensive however, did not always meet the needs of children and young people as nursing and medical staff had not been kept up to date with their mandatory training.

For example, of the 142 eligible nursing staff, 63% had completed a medicine management mandatory training module within the required timeframe set by the trust. Of the 28 eligible medical staff, 53% had completed the same module despite medication errors featuring as one of the top three risks at the time of our inspection for the department.

Medical staff failed to meet any of the mandatory training targets set by the trust with only three percent having completed manual handling training and 57% infection prevention.

During our inspection managers were in the process of altering the arrangements for booking mandatory training courses for registered nursing staff. Previously, individuals had booked onto courses themselves however, the dedicated practice development nurse for the department had begun to allocate courses through the electronic rostering system. The interim matron for the department told us this was to be reviewed on a weekly basis going forward.

Training level compliance was found to be below the required trust standard at our previous inspection of the service in 2015.

Training for the deteriorating patient including sepsis featured as part of a trust wide deteriorating patient initiative however the trust was unable to provide training compliance figures specific to this service.
Safeguarding

The service did not comply with the child protection information sharing standard designed to safeguard children who were looked after or in protection. Staff understood how to protect children, young people and their families from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Safeguarding training completion rates

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

Trust level

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</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>
</tr>
<tr>
<td>Protecting Vulnerable People Level 3</td>
<td>134</td>
<td>142</td>
<td>94.4%</td>
<td>95.0%</td>
</tr>
</tbody>
</table>

In children’s services the 95% target was not met for the one safeguarding training module for which qualified nursing staff were eligible.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</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>
</tr>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 3</td>
<td>20</td>
<td>25</td>
<td>80.0%</td>
<td>95.0%</td>
</tr>
</tbody>
</table>

In children’s services the 95% target was met for one of the two safeguarding training modules for which medical staff were eligible.

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw examples of professional curiosity during our inspection and spoke to staff who knew how to identify children at risk of or suffering from harm or abuse. A screening tool was used to identify children at risk of child sexual exploitation.
Despite the trust declaring compliance, the nationally approved information sharing system was not in use within the department for children arriving as an unscheduled admission. This was not in line with standard 36, Facing the Future: Standards for children in emergency care and meant that important information relating to looked after children or children on child protection plans may not be shared with or received from other agencies. Since the inspection the trust have told us that this has now been activated and integrated the national database into their standing procedures and processes.

There was a safeguarding policy in place and a safeguarding team to support the service which included an appointed team member responsible for children’s services. This team member attended multidisciplinary meetings and reviews.

A child abduction policy was in place for the service as well as a ‘was not brought’ policy for children failing to attend outpatient appointments. Staff understood this and gave an example of where this event had triggered a safeguarding referral.

An updated safeguarding training strategy had been approved in May 2019, but implementation had been delayed until December 2019. This strategy included a blend of face to face training as well as electronic learning with a view to promoting learning by discussion. A new safeguarding children’s policy was due to be presented to the trust committee in the weeks following our inspection.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Not all staff had completed the infection and control training and infection prevention and control audits demonstrated repeated issues with the cleanliness of premises within the neonatal area.

CQC Children and Young People’s Survey 2016

In the CQC Children and Young People’s Survey 2016 the trust scored 9.4 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

An audit of the neonatal area carried out by the infection control team in September 2019 identified several issues including linen which was deemed unclean or not in good repair, sharps bins used for disposal of waste other than sharps, unclean bed rails and dust in either high or low surfaces. Dust in various areas of the neonatal unit had been highlighted in audits in September 2019, March 2019, December 2018 and April 2018. This is a concern because removal of environmental dust is a key factor in preventing infections in infants and is not in line standard principle one of the Epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England.

An action plan was put into place following the initial September 2019 neonatal unit audit and a repeat audit undertaken 12 days later, this found that of the 36 issues identified 30 had been resolved.
The children’s ward audit in May 2018 highlighted infection, prevention and control mandatory training compliance as below the required level set by the trust. Information provided by the trust demonstrated this was still the case with 80% of nursing staff and 57% of medical staff having completed the module against a target of 95% at the time of our latest inspection.

Hand hygiene audits for all areas demonstrated high compliance and were in line with trust policy and standard principle six decontamination of hands Epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe as clinical areas within the neonatal unit were used as storage areas. The national standard for cot space could not be met was not met due to the size of the unit and we identified numerous gaps in daily checks of equipment within the paediatric assessment unit.

Access to both the neonatal and children’s ward was secure, whilst access to the paediatric assessment unit was via the children’s emergency department which was also secure however, the rear entrance could be accessed freely.

Within the dedicated children’s outpatient department, there was a secure outside space where children could play freely. There were toys and books which were included within the cleaning schedule, bright posters and murals and a fish tank.

The size of the environment within the neonatal area meant the department could not comply with the national guidance of the British Association of Perinatal Medicine cot space standard. A lack of storage space meant that areas of the unit such as intensive care had equipment and supplies stored on the floor within the clinical area. This posed a risk of both infection control and injury to patients, staff and relatives. The services however, was working hard to address this and had been named as the trust charity of the year. Fundraising initiatives were underway and plans for an extension to the area were in the process of being drawn up.

Staff carried out daily safety checks of specialist equipment such as resuscitation equipment in all areas of the service.

There was enough suitable equipment to help them to safely care for children and young people. However, routine equipment checks were not always completed within the paediatric assessment unit. For example, during our inspection we saw that a transfer bag and an airway bag had between two and five consecutive days of being unchecked.

Assessing and responding to patient risk

Staff did not complete updated nursing risk assessments for each child and young person and there was no designated mental health assessment provision for children outside of office of hours. This meant staff could not effectively identify children and young people at risk of harm or deterioration.

CQC Children and Young People’s Survey 2016

In the CQC Children and Young People’s Survey 2016 the trust scored 9.4 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.
In the CQC Children and Young People’s Survey 2016 the trust scored 7.4 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.8 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was better than other trusts.

CQC Children and Young People’s Survey 2016 questions, safe domain, Wirral University Teaching Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>9.4</td>
<td>About the same as other trusts</td>
<td>S1</td>
</tr>
<tr>
<td>20</td>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.4</td>
<td>About the same as other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>36</td>
<td>Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.8</td>
<td>Better than other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

The service did not have 24-hour or weekend access to mental health liaison or specialist mental health support. This meant if staff were concerned about a child or young person’s mental health outside of normal office hours the child would be admitted onto the general paediatric ward and wait to be assessed. This could be more than 60 hours if the patient attended on Friday evening.

An initial self-risk assessment was designed to be completed by staff with the patient on arrival to the ward in this instance however during our inspection staff told us this form was unavailable. One patient record we checked contained no evidence of a self-risk assessment. A registered nurse and medic from the paediatric ward decided together whether the patient required one to one support during their time on the ward. Information provided by the trust demonstrated that staff had no specific training in child and adolescent mental health although a one-hour training session would be developed for some time in 2020.

Ligature cutters were available within the service in line with the trust policy and staff had completed an electronic learning package to learn how to use them.

During our inspection we looked at 13 patient records and found no evidence of nursing risk assessments including pain, nutrition or pressure areas in 11 of the records. This was a concern of safety because without the correct assessments being undertaken early identification of deterioration could not be determined and pain in children can frequently be under-recognised.
Staff used a nationally recognised clinical assessment tool to identify children or young people at risk of clinical deterioration and escalated them appropriately and undertook training in paediatric life support, we saw that five additional staff were booked onto a course in December and senior members of staff were trained in advanced paediatric life support. Medics were also trained in advanced paediatric and neonatal life support.

Staff within the service attended emergencies within the accident and emergency department, a bleep for this was held by the nursing coordinator. Access to the opinion of a consultant paediatrician was available 24 hours a day which was in line with national standard.

Shift changes and handovers included all necessary key information to keep children and young people safe, during our inspection we attended a safety huddle which was held twice daily within the service, information around planned discharges, clinical assessments, safeguarding issues and staffing levels were discussed.

Sepsis checks were undertaken, and a pathway had recently been devised by an advanced nurse practitioner for use within the service. Anaphylaxis, hypoglycaemia and neonatal boxes were available but not one for sepsis. The boxes were pre-filled and meant that in an emergency all necessary equipment was available quickly.

Resuscitation trolleys were available and fully stocked in all areas of the service with the exception of the neonatal unit. In the case of a resuscitation trolley being required in this area, a member of staff would retrieve it from the labour ward within the maternity department.

**Nurse staffing**

The service had enough nursing staff and support staff to keep children and young people safe. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance.

**Trust level**

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>0%</td>
<td>10%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>296.3</td>
<td>0%</td>
<td>8%</td>
<td>5.4%</td>
<td>5,499 (3%)</td>
<td>1,702 (1%)</td>
<td>1,129 (1%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>125.3</td>
<td>-3%</td>
<td>6%</td>
<td>5.2%</td>
<td>5,499 (3%)</td>
<td>1,702 (1%)</td>
<td>1,129 (1%)</td>
</tr>
</tbody>
</table>
Nurse staffing rates within children's services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness, turnover and agency use.
Vacancy rates

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from October 2018 to March 2019.

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

Bank staff usage

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives show a shift from December 2018 to May 2019.

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

During our inspection we reviewed 14 shifts across three weeks of rotas upon the children’s ward. Out of the 14 shifts four shifts had a registered nursing gap on a day shift. On one of the days we checked there were seven registered nurses on duty which included one co-ordinator who was not supernumerary and three health care assistants. On this day there were seven patients under the age of two and 14 patients aged 2 – 14. This was in line with the Royal College of Nursing guidance on defining staffing levels for children and young people’s services. We saw that an additional five registered nurses had recently been recruited.

A consultant nurse had recently been appointed to the service and several advanced paediatric nurse practitioners and one advanced neonatal nurse practitioner provided clinical support and leadership. Specialist respiratory, epilepsy and diabetic nurses provided care to children and young people as both in and outpatients.

The paediatric assessment unit was staffed with two registered nurses. There was no health care assistant or administration support. Staff we spoke to told us the lack of a health care assistant
meant that the nursing staff workload was high and sometimes all tasks could not be completed within a timely manner.

The service had reducing rates of bank and agency nurses. A monthly report was collated and sent to senior manager to monitor usage. We saw that a local induction was given to bank or agency staff however, staff told us most shifts were covered by their own members of staff working on bank shifts. Managers reviewed each rolling seven-day rota to ensure there was the correct level of skill including a member of staff with advanced paediatric life support training. They told us that trying to calculate staffing levels with seasonal variation was difficult as no specific tool was used.

The service had considered succession planning of an ageing workforce and had begun to put control measures in place. The measures were not specific or measurable for example “looking at rotational posts to attract additional staff” however there was a clear action listed within the children’s ward improvement plan and was rated as green meaning complete.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment.

Trust level

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>0%</td>
<td>10%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>296.3</td>
<td>0%</td>
<td>8%</td>
<td>5.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>43.0</td>
<td>-2%</td>
<td>22%</td>
<td>0.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NB: Negative numbers mean that the staffing is over establishment.

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

Medical staffing rates within children’s services at the trust were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness and turnover.

Vacancy rates
Monthly vacancy rates over the last 12 months for medical staff shows a downward trend from July 2018 to November 2018. The trust medical staff was over established in June 2018, September 2018 to December 2018, April 2019, and May 2019.

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

**Staffing skill mix**

In March 2019, the proportion of consultant, middle career, registrar group and junior staff reported to be working at the trust was like the England average.

**Staffing skill mix for the 43 whole time equivalent staff working in services for children and young people at Wirral University Teaching Hospital NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>44%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends. Neonatal consultants were on site between 9am and 7pm weekdays and 9am to 11am at weekends. Whilst the paediatric consultants were on site between 9am and 7pm weekdays and 9am to 12pm at weekends. In practice consultants remained on site often until 9pm at night.
Doctors we spoke to told us the registrar rota within the neonatal area was particularly intense despite information that was provided by the service which demonstrated reducing vacancy rates for its medical staff.

Listed within the risk register was a shortage of tier one and tier two medical trainees which meant that more senior colleagues were picking up additional tasks usually undertaken by the trainees. The service had sited planning measures to counteract this but had found the reduction in numbers had been quicker than initially planned. Plans included increasing its non-medical workforce with eight advanced paediatric nurse practitioners, medical leads were working with the medical training initiative to bring across doctors from abroad and adverts had been placed for tier one and two locum doctors.

**Records**

*Staff kept detailed records of children and young people’s care and treatment. Records were clear, stored securely and easily available to all staff providing care.*

All records were stored securely. Patient notes were comprehensive, and all staff could access them easily. We reviewed 11 patient records, each one contained evidence of a diagnosis and management plan and discussion with the patient and family/carer. Records were clear and legible.

**Medicines**

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

Staff stored and managed medicines and prescribing documents in line with the provider’s policy.

Electronic prescribing was in place within the service since August 2019. A consultant pharmacist for the service reviewed children and young people’s medicines daily and provided specific advice to children, young people and their families about their medicines.

Medicines were managed by independent prescribers and by patient group directives which were all in date and correctly documented in line with national standards.

Medicine errors sat within the top three risks on the service risk register with 32 errors our of 166 incidents over a six-month period. The consultant pharmacist had put in place training sessions with independent prescribers to reduce this and alterations were made to the mandatory training booking process to improve medicine management training. At the time of our inspection 67% out of 142 registered nurses and 53% of the 28 medical staff eligible had undertaken the mandatory medicine management module.

Stock levels, drug expiry dates and daily room temperatures were checked, and controlled drugs checks completed twice daily.

**Incidents**

*The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support.*
Never Events

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

From July 2018 to June 2019, the trust reported no never events for children’s services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) which met the reporting criteria set by NHS England from July 2018 to June 2019.

(Source: Strategic Executive Information System (STEIS))

The service had no never events on any wards.

Incident reporting had been part of the focus of the children’s ward improvement plan and work had been undertaken to raise awareness of the importance of an incident reporting culture. The service had seen an increase in the number of incidents reported and staff we spoke to knew what incidents to report and how to report them in line with trust policy.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if things went wrong. Duty of candour prompts on an electronic incident report form meant that staff could not progress an incident until the duty of candour prompt was checked. This added as additional assurance for the service that it had been considered and acted upon.

Monitoring of serious incident duty of candour for all incidents of moderate and above took place weekly by a central serious incident team.

Clinical incidents were received by a central email box and then distributed for investigation appropriately. Incidents were discussed at the weekly divisional clinical improvement forum and monthly health and safety meetings.

Staff received feedback from investigation of incidents, both internal and external to the service. And lessons learnt from incidents were shared with staff at regular meetings, via closed social media group, generic email and via displayed posters in areas such as the toilet or the staff room.

Safety thermometer

The service used safety monitoring. Staff collected safety information and shared it with staff, children, young people, their families and visitors.

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

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date. Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from May 2018 to May 2019 for children’s services.

(Source: NHS Digital)

Data submitted showed that out of 160 patients surveys, none had developed pressure ulcers, had falls with harm and no new urinary tract infections in patients with a catheter within the reporting period. Gaps identified in the completion of nursing assessments followed by subsequent improvement measures taken meant that future monitoring could be accurately undertaken.

Is the service effective?

Evidence-based care and treatment.

The service provided care and treatment based on national guidance and evidenced-based practice.

The department took part in a monthly children’s guideline and procedure group where changes were discussed and recommendations to practice made. National institute for Health and Care Excellence quality standards and guidance were discussed at these meeting. Any recommendations were then escalated to the board for approval.

We reviewed some of the service policies. The policies were up to date and based on national policy including the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Paediatrics and Child health (RCPCH).

Policies were available to all staff on the electronic intranet system and staff demonstrated they knew how to access them.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Snack bags were available to children if they had missed dinner.

Specialist support from staff such as dieticians was available for children and young people who needed it, a feeding support notice board was displayed in the ward area and contained information such as when the dietician was visiting.

Where specific nutrition was prescribed we saw evidence of this being given.

Facilities were available in areas of the neonatal unit and throughout the women’s and children building to enable mothers to breast feed or express their breast milk for their baby.

Pain relief
Staff did not assess children and young people regularly to see if they were in pain, and therefore could not be certain pain relief was given in a timely way.

During the inspection we were not assured that pain assessments were always being undertaken and recorded. During the inspection we looked at 13 patient records and found that only one record had a pain assessment documented. This was not in line with best practice guidance given that pain in children can frequently be under-recognised.

Once pain had been identified, children and young people did receive pain relief in a timely way.

Following our inspection information provided to us by the service demonstrated that pain assessments had been included within a local perfect ward application which was completed daily. If a patient answered yes or showed signs of pain a more in-depth assessment tool was completed.

Managers were monitoring three records weekly to ensure this was being undertaken appropriately.

Patient outcomes

- Staff monitored the effectiveness of care and treatment through audit. However, there was limited evidence of use of the findings to make improvements.

Paediatric diabetes audit

The table below summarises Wirral University Teaching Hospital NHS Foundation Trust performance in the 2017/18 National Paediatric Diabetes Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion rate for key health checks for patients aged 12+ (There are seven key care processes recommended by NICE for patients with Type 1 diabetes that should be performed at least annually)</td>
<td>80.3%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted mean HbA1c (HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled. This measure is provided for benchmarking against other providers during an audit year)</td>
<td>71.1</td>
<td>Worse than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>Median HbA1c (This measure is provided to give an indicator of how performance has changed between the previous and latest audit reports. A change of 1 mmol/mol is deemed to be clinically significant)</td>
<td>68.0</td>
<td>Clinically significant decline</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Paediatric Diabetes Audit)

The 2017/18 Royal College of Paediatrics and Child Health National Paediatric Diabetes Audit showed 141 children suffering from type one diabetes (a condition where blood glucose levels are too high because the body can't make a hormone called insulin), 42% of which were aged between
ten and 14 years of age.

HbA1c levels are an indicator of how well an individual’s blood glucose level is controlled over time. The National Institute for Health and Care Excellence national guideline NG18, Diabetes (type 1 and type 2) in children and young people: diagnosis and management recommend that all children and young people with diabetes should have their HbA1c measured at least four times a year. Of the 114 patients eligible, 100% received a HbA1c measurement on at least four occasions annually during this audit. However, only 75% of patients received an annual thyroid check and 53% of patients over the age of twelve received an annual test for albuminuria against an England and Wales score of 84% and 74% respectively.

Currently a hospital at home service is offered seven days a week and newly diagnosed patients are stabilized at home with the support of early dietetic intervention when carbohydrate counting is begun.

In response to this and the national paediatric diabetes spotlight audit in 2017/18 the trust had written an action plan where it committed to undertaking a capacity and demand review, the submission of a business case to increase the number of diabetic clinics and the provision of 24-hour clinical telephone advice about diabetes management. The completion date for these actions were the 30 January 2020. No evidence was provided to demonstrate the progress of these actions.

**National Neonatal Audit Programme**

The table below summarises Arrowe Park hospital performance in the 2018 National Neonatal Audit Programme against measures related to neonatal care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do all babies &lt;32 weeks gestation have a temperature taken within an hour of admission that is 36.5°C-37.5°C? (Low body temperature on admission is associated with increased complications, such as hypoglycaemia, jaundice and respiratory distress, and death in pre-term infants)</td>
<td>55.6%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission? (Timely consultation with parents/carers is crucial to allaying fear and anxiety and improves the parent/carer experience)</td>
<td>93.2%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Do all babies &lt; 1501g or a gestational age of &lt; 32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP) (ROP is a preventable cause of blindness in pre-term infants provided it</td>
<td>95.7%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age? (It is important that the development of pre-term babies is monitored by a paediatrician or neonatologist after discharge from the neonatal unit)

<table>
<thead>
<tr>
<th></th>
<th>Arrowe Park hospital</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency readmissions within two days of discharge among the under 1 age group, by treatment specialty (February 2018 to January 2019)</td>
<td>Did not meet</td>
<td>64.4%</td>
</tr>
<tr>
<td>There were no emergency readmissions after elective admission at Arrowe Park hospital among patients in the under 1 age group from February 2018 to January 2019.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There were also no emergency readmissions within two days of discharge for patients aged 1-17 years old following an elective admission.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

During our inspection we were told a gap analysis was being undertaken to identify the requirements to fully meet the Mothers and Babies Reducing Risk through Audit and Confidential Enquiries and National Neonatal Audit Programme recommendations however this had not begun at the time of requesting the evidence.

Emergency readmission rates within two days of discharge

The data shows that from February 2018 to January 2019 there were no emergency readmissions within two days of discharge for patients under one following an elective admission.

There were no emergency readmissions after elective admission at Arrowe Park hospital among patients in the under 1 age group from February 2018 to January 2019.

There were also no emergency readmissions within two days of discharge for patients aged 1-17 years old following an elective admission.

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that from February 2018 to January 2019 there was a higher percentage of under ones readmitted following an emergency admission compared to the England average for paediatrics.

For patients aged 1-17 years old, there was a higher percentage of patients readmitted following an emergency admission compared to the England average for paediatrics and also compared with the England average for general surgery.
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Readmission rate</th>
<th>Discharges (n)</th>
<th>Readmissions (n)</th>
<th>Readmission rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatrics</td>
<td>5.8%</td>
<td>1,704</td>
<td>98</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

**Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (February 2018 to January 2019)**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Arrowe Park hospital</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatrics</td>
<td>6.2%</td>
<td>4,109</td>
</tr>
<tr>
<td>General surgery</td>
<td>5.0%</td>
<td>220</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

(Source: Hospital Episode Statistics)

**Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes**

From March 2018 to February 2019 there were no multiple readmissions of patients under the age of one for Asthma and Diabetes at the trust. The multiple readmissions of patients under the age of one for Epilepsy have been suppressed due to small numbers.

The trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma.

The trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for diabetes and epilepsy.

**Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (March 2018 to February 2019)**

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Wirral University Teaching Hospital NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1-17</td>
<td>13.6%</td>
<td>110</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1-17</td>
<td>30.8%</td>
<td>26</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>0.0%</td>
<td>*</td>
</tr>
<tr>
<td>1-17</td>
<td>33.3%</td>
<td>30</td>
</tr>
</tbody>
</table>

Notes: To protect patient confidentiality, figures between 1 and 5 and their associated proportions have been suppressed and replaced with “*” (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed. The “-” (a hyphen) in the table indicates that there were no admissions for these long term condition or age groups.
The trust provided details on their ongoing programme of national clinical audit for children’s services, which demonstrated a commitment to reviewing and monitoring patient care with the emphasis on improving outcomes for patients. The audits included the management of neonatal hypoglycaemia, resuscitation equipment and emergency airway audit, diabetes, abdominal pain, croup and the new born and infant physical examination audit.

Managers and staff used the results to improve children and young people's outcomes. For example, a service evaluation project was approved in response to the assessment of hearing in children with suspected autism spectrum disorder and gap analysis to ensure the department was complaint with the National Institute for Health and Care Excellence national guidelines such as 127 Suspected neurological conditions: recognition and referral

Resuscitation audits were completed in both the children’s ward and the neonatal area and achieved 90% and 100% respectively.

Managers told us they were focusing on the reasons for re-admission and exploring ways of reducing admissions, one measure put in place was the discussion with a senior clinician of all medical patients discharged in line with the Royal College of Paediatric and Child Health standard.

The trust participated in the National Maternity and Perinatal Audit, a national audit of the NHS maternity and neonatal service in 2017, The results of the 2017 audit were published in September 2019 and were due to be presented at clinical governance meetings and patient safety and quality board to promote discussion about the standards and raise awareness.

**Competent staff**

The service did not always make sure staff were competent for their roles as no mental health awareness training was provided despite staff regularly caring for children and adolescents with symptoms of mental health illness.

During the inspection staff told us that they did not receive training in mental health. We found that there were times when children and adolescents had been admitted who required support due to mental health illnesses. We were not provided with any evidence following inspection of any awareness training for staff in the service.

**Appraisal rates**

**Trust level**

From April 2018 to March 2019, 87.3% of required staff within children’s services received an appraisal compared to the trust target of 88.0%.

The breakdown by staff group can be seen in the table below:
Managers supported staff to develop through yearly, appraisals of their work. We saw a high number of staff had received an appraisal and changes within the leadership team of the service had meant that clinical supervision and the facilitation of training were now undertaken.

Managers gave all new staff a full induction tailored to their role before they started work this was supported by a preceptorship period which included a period supernumerary hour.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Newsletters such as the clinical governance gem were circulated to the team and a stand up to solutions meeting gave staff the opportunity to present solutions to problems the service faced.

No training was offered to clinical staff on recognising and responding to children and young people with mental health needs, learning disabilities and autism.

A newly recruited in house clinical educator was working with the leadership team to identify training needs within the service. Staff had the opportunity to discuss their training needs with both their line manager or clinical educator. Staff told us they were supported to develop within their role and could request to attend any relevant training. For example, a breast-feeding course.

Senior nurses were asked to consider what was considered essential training for their service. Following this the service provided an additional study day for staff which included the topics diabetes, asthmas and epilepsy management. Allergy awareness and additional safeguarding discussions were also considered by staff members to be essential training for the service.

**Multidisciplinary working**

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

**CQC Children and Young People’s Survey 2016 – Q23**

In the CQC Children and Young People’s Survey 2016 the trust scored 9.2 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
We observed good multi-disciplinary working during the inspection. Staff showed respect for each other and the expertise each brought to the care of patients. They worked collaboratively together for the benefit of patients.

Staff held regular and effective department multidisciplinary meetings to discuss children and young people and improve their care. Speech and language teams from a dedicated children’s hospital undertook assessments of neonatal patients.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression and staff told us that if they contacted the service before 11am, the patient could be seen the same day. However, doctors told us it was difficult to get patients seen by the service and there was no evidence of any joint working with the mental health provider to address the difficulties the service faces in obtaining mental health assessments for children and young people.

The service was part of the North West allergy network group,

**Seven-day services**

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

Consultants led daily ward rounds where children and young people were reviewed depending on the care pathway seven days a week. Overnight a senior doctor reviewed patients and could contact an on-call consultant when required.

Staff could call for support from doctors and other disciplines, and diagnostic tests such as x-rays were available seven days a week.

**Health promotion**

*Staff gave children, young people and their families practical support and advice to lead healthier lives*

Health promotion leaflets were available within the service and minutes from a clinical governance meeting in August 2019 listed the consideration for the introduction of smoking cessation advice leaflets into clinical practice.

**Consent, and mental Capacity Act**

*Staff did not receive training to support children, young people and their families who lacked capacity to make their own decisions.*

**Other CQC Survey Data**

**CQC Children and Young People’s Survey 2016 Data**

The trust performed the same as other trusts for all four questions relating to effectiveness in the CQC Children and Young People’s Survey 2016.

**CQC Children’s Survey questions, effective domain, Wirral University Teaching Hospital NHS Foundation Trust**
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9</td>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>19</td>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>33</td>
<td>Did different staff give you conflicting information?</td>
<td>0-15 adults</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>54</td>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 CYP</td>
<td>No Score</td>
<td>No Score</td>
</tr>
</tbody>
</table>

Where options were provided that did not have any bearing on the trust’s performance, in terms of patient experience, the responses are classified as “not applicable” and no score is given. Where respondents stated they could not remember or did not know the answer to a question, no score is given.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Staff made sure children, young people and their families consented to treatment based on all the information available. We observed staff seeking consent appropriately from children attending the operating theatre including explaining the treatment fully. However, some staff we spoke to during the inspection were unclear of Gillick and Fraser competencies, which apply to assessing the competence of children and young people to consent to treatment.

Whilst medical staff were aware of the Mental Capacity Act (2005) and the implications for young people between 16 and 18 years of age. Clinical staff had not received training in the Mental Capacity Act and Deprivation of Liberty Safeguards despite caring for patients of this age.

There was no mental health awareness training in children’s and young people’s services despite staff regularly caring for children and adolescents with symptoms of mental health illness. There was only a pilot that was being undertaken at the time of the inspection. They did not receive sufficient training to support those who lacked capacity to make their own decisions in these services.

A consent 2018 audit carried out by the trust demonstrated that of 46 paediatric cases written consent was given in 100% of cases and consent was taken at the point of anaesthesia in 98% of cases.

**Is the service caring?**

**Compassionate care**

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

CQC Children and Young People’s Survey 2016
The trust performed better than other trusts for four questions and about the same as other trusts for the remaining six questions relating to compassionate care in the CQC Children and Young People’s Survey 2016. The trust performed better than other trusts for the below questions:

- Do you feel that the people looking after your child were friendly?
- Do you feel that your child was well looked after by the hospital staff?
- Do you feel that you (the parent/carer) were well looked after by hospital staff?
- Was it quiet enough for you to sleep when needed in the hospital?

CQC Children and Young People’s Survey 2016 questions, compassionate care, Wirral University Teaching Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>14</td>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>22</td>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>42</td>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.5</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>43</td>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>9.6</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>44</td>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>8.9</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>58</td>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 CYP</td>
<td>7.6</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>64</td>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 CYP</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>74</td>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 CYP</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>75</td>
<td>Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 CYP</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Staff were discreet and responsive when caring for children, young people and their families. During our inspection we saw that staff took time to interact with children, young people and their families in a respectful and considerate way.

Children, young people and their families said staff treated them well and with kindness which was mirrored in the return of the friends and family test. Information on the quality dashboard for the division showed a 19% response rate for the directorate in September 2019 staff told us that 97% of the responses completed were positive. As was the children and young people’s survey 2016 in which parents said they felt staff were friendly.
Staff followed policy to keep care and treatment confidential, were careful to be discreet when discussing care with other healthcare professionals and displayed caring non-judgmental attitudes to all patients including those suffering from mental health.

**Emotional support**

Staff provided emotional support to children, young people, families and carers to minimise their distress. They understood children and young people's personal, cultural and religious needs.

**CQC Children and Young People’s Survey 2016**

The trust performed better than other trusts for one question and about the same as other trusts for the remaining four questions relating to emotional support in the CQC Children and Young People’s Survey 2016. The trust performed better than other trusts for the question; If you felt pain while you were at the hospital, do you think staff did everything they could to help you?

**CQC Children and Young People’s Survey 2016 questions, emotional support, Wirral University Teaching Hospital NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>29</td>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>45</td>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>65</td>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 CYP</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>67</td>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>9.4</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Staff gave children, young people and their families help, emotional support and advice when they needed it. A quiet room was available for both patients and parents and accommodation was available so that parents could stay at the hospital with their children for as long as possible. This was provided in conjunction with a national charity.

We saw staff laughing with patients and engaging in personalised conversation as well as reassuring patients who were upset or frightened.

A chaplaincy team was available to support spiritual and religious needs for both children and their relatives and we saw a ‘before and after’ photograph board was displayed at the entrance to the
neonatal area. This showed children who were born prematurely and then again some years later. The board was entitled Ohana which staff told us meant family and explained that within family nobody gets forgotten and so to acknowledge the journey of children who had passed away their photographs had also been included and were displayed.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

CQC Children and Young People’s Survey 2016

The trust performed better than other trusts for one question and about the same as other trusts for the remaining 17 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. The trust performed better than other trusts for the question; Did members of staff treating your child communicate with them in a way that your child could understand?

CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, Wirral University Teaching Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>12</td>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>8.4</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>13</td>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>15</td>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>16</td>
<td>Were you given enough information to be involved in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>17</td>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>18</td>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>31</td>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Before the operations or procedures, did a member of staff answer your questions in a way you could understand? 0-15 adults 9.6 About the same as other trusts
Afterwards, did staff explain to you how the operations or procedures had gone? 0-15 adults 9.0 About the same as other trusts
When you left hospital, did you know what was going to happen next with your child's care? 0-15 adults 8.6 About the same as other trusts

Do you feel that the people looking after your child listened to you? 0-7 adults 9.1 About the same as other trusts
Did hospital staff talk with you about how they were going to care for you? 8-15 CYP 9.3 About the same as other trusts
When the hospital staff spoke with you, did you understand what they said? 8-15 CYP 8.7 About the same as other trusts
Did you feel able to ask staff questions? 8-15 CYP 9.5 About the same as other trusts
Did the hospital staff answer your questions? 8-15 CYP 9.6 About the same as other trusts

Were you involved in decisions about your care and treatment? 8-15 CYP 6.0 About the same as other trusts
If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there? 12-15 CYP No Score No Score
Before the operations or procedures, did hospital staff explain to you what would be done? 8-15 CYP No Score No Score
Afterwards, did staff explain to you how the operations or procedures had gone? 8-15 CYP No Score No Score
When you left hospital, did you know what was going to happen next with your care? 8-15 CYP 7.4 About the same as other trusts

Where options were provided that did not have any bearing on the trust’s performance, in terms of patient experience, the responses are classified as “not applicable” and no score is given. Where respondents stated they could not remember or did not know the answer to a question, no score is given.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Staff made sure children, young people and their families understood their care and treatment. They talked in a way they could understand, using communication aids where necessary. Both nursing and medical staff members spoke daily to the patients and their relatives, we saw that they explained what was happening to the patient, what option of treatments were available and gave opportunity for questions and discussion.

Notice boards entitled ‘This Week’ and ‘Family integrated care’ provided lots of information to patients and parents around their involvement in various aspects of care. Parent groups were held weekly within the neonatal department.
Feedback was captured in the form of patient survey, family and friends tests and children’s comments were displayed on a noticeboard called ‘fish thinking’.
Is the service responsive?

Service delivery to meet the needs of local people

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

CQC Children and Young People’s Survey 2016

The trust performed better than other trusts for one question and about the same as other trusts for the remaining 13 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016. The trust performed better than other trusts for the question; Did a member of staff tell you who to talk to if you were worried about your child when you got home?

CQC Children and Young People’s Survey 2016 questions, responsive domain, Wirral University Teaching Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>5</td>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child’s physical or medical needs?</td>
<td>0-15 adults</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>25</td>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>26</td>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>4.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>28</td>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>55</td>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>No Score</td>
<td>No Score</td>
</tr>
<tr>
<td>8</td>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>24</td>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>37</td>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>38</td>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>9.4</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>40</td>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>56</td>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>57</td>
<td>Did you like the hospital food?</td>
<td>8-15 CYP</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Did a member of staff tell you who to talk to if you were worried about anything when you got home?

Did a member of staff give you advice on how to look after yourself after you went home?

Did the hospital give you a choice of admission dates?

Did the hospital change your child’s admission date at all?

Where options were provided that did not have any bearing on the trust’s performance, in terms of patient experience, the responses are classified as “not applicable” and no score is given. Where respondents stated they could not remember or did not know the answer to a question, no score is given.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

The service was located within the women’s and children building. When accessing the service via the front entrance there was nothing which welcomed children or indicated a children’s service was within the building. For example, there were no bright murals, no colourful lines or signage indicating which way to go. Once on the ward however, the entrance and that of the outpatient department and paediatric assessment unit were bright and colourful. A fish tank was located near to the reception of the outpatient’s department.

Agreements were in place to ensure specific patients had rapid access to paediatric care by way of a passport system. This meant the accident and emergency department could be bypassed and the patient brought directly to the ward. Agreed guidelines were also in place for the referral of paediatric outpatients from primary care.

A satellite outpatient clinical was available at a tertiary centre in the surrounding area meaning a benefit for patients who could not easily travel to the main site.

Managers monitored and acted to minimise missed appointments and a ‘was not brought’ policy was in place which included making contact with children, young people and their families. Staff we spoke to during the inspection understood the significance of this policy and what actions to take in the event of a child not be brought to an appointment.

The service worked hard to accommodate parents, relatives and families. On the children’s ward parents were able to stay with their children. Fresh fruit was provided once a week and hot meals were provided for parents who could also help themselves to hot drinks and refreshments. On the neonatal unit parents had their own kitchen and quiet area. Dedicated accommodation was also available and ran in conjunction with a national charity.

A separate area for adolescents known as the ‘chill zone’ was on the ward and Wi-Fi was also available which meant patients could keep in touch with family and friends.

The trust told us that work was being undertaken with the local women’s and children’s partnership to develop a competency framework regarding the emotional health and wellbeing of children and young people a half day training session was being planned they said in spring 2020.
Meeting people’s individual needs

The service did not always take account of children, young people and their families’ individual needs and preferences such as those attending outpatient appointment in the main hospital.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. This was from a third party and in the form of telephone translation and face to face if required. This service was available to staff.

A sensory room was available within the ward area which provided distraction and relaxation to both patients and relatives. And a small electric car meant that patients could ‘drive’ themselves accompanied to theatre.

At the time of our inspection the there was only one play specialist working with the service. Managers told us they were in the process of recruiting another specialist however this was not in line with Royal College of Paediatric and Child Health guidelines and meant that the play area with the ward was only available between the hours of 9am and 5pm and no play specialist was available to support children seen in other areas of the trust such as the ear nose and throat or ophthalmology outpatient departments.

The environment of the ear nose and throat and ophthalmology outpatient clinic was not adapted for children, adolescents or young people as there were no facilities to meet their needs. No toys were available, the seating area was insufficient for a large clinic of up to 40 patients and there was nothing to distract anxious or distressed children when consultations or minor procedures were undertaken, and staff told us children’s appointments were often intermingled with adult appointments in the clinics to depending on demand. Information provided to us by the trust demonstrated that during the last six-month period nearly 3000 children were seen within the main outpatient department for the hospital.

The service had information leaflets available in English only for children, young people, their families and local community.

Since our last inspection the Learning Disability Liaison Team has integrated within the safeguarding team. Notification of all children and young people who were admitted within the service went to the central team who could then support the patients appropriately. Patients with additional needs were offered face to face pre-operative assessments and were prioritised to be seen quickly to minimise distress.

Access and flow

People could access the service when they needed it and there were appropriate systems in place for the referral and assessment of urgent and emergency patients.

Neonatal Critical Care Bed Occupancy

From July 2018 to June 2019, the trust has seen neonatal bed occupancy levels fluctuate across the period. The unit was at 100% occupancy for three of the monthly snapshots but lower than the England average for eight months during the period.
Children were admitted to the paediatric assessment unit either by referral from their GP or from the emergency department. From here, patients could be admitted to the ward or observed on the unit or discharged home. The children’s wards also admitted a small proportion of children for planned surgery.

The service did not always meet the standard for review of all patients admitted to the paediatric wards by a consultant paediatrician within 14 hours of admission. However, consultants undertook daily ward reviews and attended all handovers and safety huddles. Patients were seen by a middle grade doctor on the paediatric rota within four hours of admission.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. Medics undertook daily ward rounds and information sharing at safety huddles and staff handovers meant that planning for discharge was the responsibility of the whole team. And daily pharmacist reviews meant that patients were not waiting lengthy times for medications.

Children using the children’s outpatient service were referred by their GP or a consultant following admission to the wards.

Managers worked to keep the number of cancelled appointments to a minimum and provided additional clinics when they could. However, we saw that initial health assessments for looked after children sat on the trust safeguarding risk register. Changing clinical times following bank holidays and delays were sighted as reasons for this. Members from the service governance team told us that timescales to appointment had been changed to an exception report.

A transition policy was in place and staff worked to ‘transition’ patients smoothly between adolescent and adult services. Planning for transition of patients with allergies began at aged 14. We heard that a recent allergy workshop had been undertaken and transitioning clinics were in place for diabetes and asthma. A specialist complex case manager co-ordinated care for children and young people with complex needs. This provided a structured approach and aimed to ensure the move was a positive experience for young people. Patients with complex care needs struggled to effectively transition between services due to a lack of an effective transitional pathway into adult services.

This was highlighted upon the risk register for the division. Actions showed that the service had tried to address this in setting up a task and finish group between the itself and clinical commissioning in December 2018 however, following an extension to July 2019 no progress had been made and the group was no longer considered active. The risk score had been increased to reflect this however

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**Critical care bed occupancy – Neonatal**

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*
staff told us this had impacted upon new patients who were unable to access the support they required.

The service had seen a slight increase in the number of admissions to 8000 between the period of July 2018 and June 2019.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Summary of complaints

Trust level

From July 2018 to June 2019 the trust received 11 complaints in relation to children’s services at the trust (4.8% of total complaints received by the trust). The trust took an average of 38.3 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be investigated and close complaints within 30 days.

However, the trust target for completing complaints prior to December 2018 had been 25, 45 or 60 working days (depending upon complexity).

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>4</td>
<td>36.4%</td>
</tr>
<tr>
<td>Communication</td>
<td>4</td>
<td>36.4%</td>
</tr>
<tr>
<td>Treatment &amp; Procedure</td>
<td>2</td>
<td>18.2%</td>
</tr>
<tr>
<td>Medication</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

From July 2018 to June 2019 there were seven compliments about children’s services at the trust.

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

Children, young people and their families knew how to complain or raise concerns and the service displayed information about how to raise a concern to the patient advice and liaison service which was in line with the formal complaint’s procedure for the trust.

Managers we spoke to told us that early conversations about any concerns as well as communication with patients and carers generally prevented matters arising and meant that the service took a proactive approach to managing concerns.
Staff we spoke to knew how to handle complaints and understood the policy around them.

Managers investigated complaints and identified themes via a central governance team. Issues, actions and responses were looked at as well as low level concerns such as an informal conversation with managers to ensure valuable information was captured. This was fed back at clinical governance and staff meetings. Robust feedback from managers was given to children, young people and their families in writing as well as individuals involved where applicable and shared learning was distributed via a weekly newsletter.

At the time of our inspection there were no outstanding complaints.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for children, young people, their families and staff. They supported staff to develop their skills and take on more senior roles.

The children’s and young people service sat within the women’s and children’s division. This service was led by a general manager, clinical director and lead nurse with support from matrons. Some of the team were in interim posts. Managers within the service were both visible and approachable and held open-door sessions for staff, patients and parents. Staff gave examples of meeting with managers following a night shift.

The senior management team told us that management meetings for women and children’s services such as performance management meetings, gave the same amount of time to discussion of children’s services as to women’s services.

Whilst the senior management team recognised their responsibility for taking an overview of services for children and young people, they did not have oversight of children that were cared for within the hospital, including those cared for in predominantly adult services and were unaware of the lack of suitability for children and young people. Managers had however, recognised certain challenges and had made attempts to improve or rectify them. We saw that the children’s improvement plan had focused on registered nurse staffing and that subsequently five appointments had been made.

Doctors spoke highly of the support they received from senior members of medical staff. Interim managers had been appointed to the children’s ward and a consultant nurse had been appointed to strengthen clinical leadership.

Equality and diversity within the service was limited to the trust learning and development pages for staff.

Vision and strategy

The service had a vision for what it wanted to achieve and was in the process of developing a strategy to turn it into action. However, there was little involvement of relevant stakeholders or the patient voice and the focus was not always aligned to key areas within the service such as mental health of children and young people.
Senior leaders told us the strategy for the women’s and children’s directorate was in the process of being refreshed. A focus group had been held between the clinical leads of paediatrics, neonatal and community services as well as the senior nursing and business lead for the department to prioritise the strategy aims.

Feedback themes included diabetic peer reviews and the investment in respiratory and epilepsy nursing. Senior leaders also told us of a desire to focus on nursing leadership, autism, learning disability and response to treatment times. However, staff had not been involved in the consultation process and there was no evidence of involvement of the patient voice or key groups representing the local community and improvement of services provided by the trust in conjunction with the mental health provider for paediatric mental health patients did not feature.

Information provided to us by the trust following our inspection demonstrated that 24-hour access to the paediatric assessment unit and children’s emergency department featured as part of the strategy.

Leaders told us work was due to commence with community trusts however this had not yet taken place.

Senior managers were unable to tell us how children accessing services in other parts of the trust were monitored and there was no joint working with the mental health provider to address the problems experienced around risk assessing children with mental health issues.

**Culture**

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**Staff felt respected, supported and valued. The service provided opportunities for career development and had an open culture where children and young people, their families and staff could raise concerns without fear.**

Staff we spoke to during our inspection told us they now felt supported and valued. The service had undertaken a culture survey as part of the children’s ward improvement plan and had put into place actions for the quality bus (a monthly initiative to attend clinical areas and sense check the environment, culture and discuss themes and quality with staff) initiative to visit the service, the Caldecott guardian and the freedom to speak up guardian. Dates for the quality bus had been actioned at the time of our inspection but not the freedom to speak up guardian or Caldicott guardian. Several staff members we spoke to during our inspection we unaware of the role of the freedom to speak up guardian.

Managers had undertaken work to promote values and expected behaviours within the service and the increase of information sharing around service provision in bulletins and newsletters such as the clinical governance gem had made staff feel more included in the day to day running of the service.

Staff were engaged in shaping the culture of the service, staff we spoke to felt proud to work with the service and we heard of examples of job offers elsewhere being turned down by staff so that they could remain with the service, one member of staff described the team and ‘family ‘whilst another told us morale had increased.

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**Governance**
Governance processes were in place throughout the service however were not always effectively implemented for example pain management policies were not always followed and local audits designed to examine care and treatment did not consider key areas such as nursing risk assessments.

A dedicated governance team sat within the women’s and children’s directorate and following several new appointments were working to further develop processes throughout the service. Several weekly governance meetings took place including paediatric and neonatal care improvement meetings which included incidents, risk and complaints and monthly mortality and morbidity meetings.

A monthly children’s clinical governance meeting was attended by the clinical service leads, assistant director of nursing, consultants, matrons and nursing staff. Attendance at these meeting was monitored and work was ongoing to improve attendance. The agenda for this meeting included a review of minutes from the patient safety and quality board, risks and actions, audit proposals, guidelines for ratification, shared learning including patient safety alerts, an investigation and financial summary. Escalation from this meeting was to the patient safety and quality board. Feedback was captured by a weekly and monthly newsletter, closed social media, generic email and print out of the minutes.

During the inspection we found gaps where the weekly sisters and monthly matrons ward audits had not been undertaken, we found that nursing risk assessment were not featured within these audits and that, the length of them varied from between five to 15 pages on each occasion they were competed meaning there was no standardised monitoring.

Since our inspection information provided to us by the trust demonstrated that nursing risk assessments were now completed and an audit of this was undertaken on a weekly basis. Training on the use of the adult pressure ulcer assessment tool was underway until a suitable paediatric specific tool was identified and work to amend the way in which the assessments were recorded electronically was underway.

The service was on target to meet the mandatory completion of the Perinatal Mortality Review Tool for 2019. This tool was designed to support its programme and provide a standardised approach to all reviews. This tool became mandatory in late 2018 however the service had decided to look retrospectively back prior to this to ensure all appropriate measures had been considered and taken.

A ‘clinical board on ward’ noticeboard was displayed which highlighted the electronic recording of clinical risk assessments and mental health assessment as area of concern.

**Management of risk, issues and performance**

*The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. There were occasions when actions to mitigate risk were not always specific.*

The trust provided a copy of a monthly performance report for women’s and children’s services at the hospital. This gave performance against key indicators such as referral to treatment times cancelled outpatient appointments, emergency re-admissions, friend and family test
results, and complaints response times; however, the information was not broken down for children’s services. Therefore we were unable to ascertain the performance of the service.

The risk register for the service set out what the risk was and who was the risk lead. It’s severity score and any control measures in place followed by action details and progress. The oldest risk for the service had been in place since 2012, and actions listed for a risk relating to children admitted to the paediatric ward from accident and emergency were not specific and did not make clear who was responsible for initiating the discussion nor whether an admission process was being created or renewed and how it would be achieved.

The top risks for the service were displayed in the ward area for staff and patients to see. Medicine management was a recurring theme as was an increase in child and adolescent mental health presentations. Risks were also highlighted in a clinical governance gem newsletter which was distributed to all staff within the service.

Anyone within the service could identify a risk and all potential risks were sent to the governance team within the service. A newly appointed lead for this team had put into place governance sessions to introduce changes made in the management of the register. For example, a risk of score of below eight was now sent back to the clinical area for management with one to one support from the governance team. This was to promote a culture of ownership and insight into risk identification and management.

Risks regularly reviewed and were presented to the risk management committee twice a month and a risk score of 10 or above was escalated to the patient safety and quality board. The highest score outstanding at the time of our inspection was a risk score of 10.

There was a sepsis lead within the neonatal area of the service and we saw that a brief discussion around the importance of the golden hour for neonatal patients had taken place at a clinical governance meeting in August 2019. However, the service had been unrepresented at the trust sepsis & deteriorating patient steering group meetings between April 2019 and September 2019.

Staff at all levels had regular opportunities to meet, discuss and learn from the performance of the service.

**Information management**

**Information systems were integrated and secure. Notifications were submitted to external organisations as required.** There were times when lack of training had resulted in inaccurate data being recorded.

Most of the patient records in children’s services were electronic and staff had access to computers in the clinical areas to enable them to view the attendances, results of investigations, medicines and ongoing record of care. Patients arrived at the ward from accident and emergency department with paper records. Neonatal medical staff recorded information on two systems which staff told us ‘doubled up work’. The prescribing of infusions, and medicines outside of specified times had also created difficulties staff told us.

Lack of training for relevant members of staff on the electronic system resulted in inappropriate ‘work arounds’ and inaccuracy of data as well as misleading information on dashboards and inaccurate
data pulls was sighted within the service risk register. An IT nurse had been recruited to the midwifery department however there were no control measures in place for the children’s service. This was for review in September 2019.

Engagement

Collaboration with service users, equality groups and the public to help improve services for children and young people did not assist in the planning and managing of such services.

Children, young people and their parents were encouraged to give their views about the service. Feedback was then displayed on the walls of the paediatric wards and neonatal unit.

Initiative such as youth forums and forums for children and parents of children with special educational needs and disabilities or the ’15 step challenge’ (designed to show the first impressions from the perspective of a child or young person within the first 15 steps from arrival such as accessibility, sounds, sights etc.) had not been implemented. This meant people who used services, those close to them and their representatives were not actively engaged or involved in decision-making to shape services and culture. Following our inspection information provided by the trust highlighted that the named nurse for children was working to improve systems processes to include the voice of the child.

The service was working to build collaborations with local networks and partnership to develop a shared understanding of challenges within the system. Examples such as the taking part in the Cheshire and Mersey Women’s and Children’s Partnership the trust told us was in development.

Learning, continuous improvement and innovation

The department was developing an understanding of quality improvement methods, because of this we were unable to determine impact at the time of the inspection.

Work was underway to introduce an electronic communication application for smart phones which would enable to unit to communicate remotely with parents, for example to notify them of a change to ward round times etc. At the time of our inspection this was not in place however.

A quality improvement programme was also underway at the time of our inspection to improve diabetes services for children and young people. Part of the focus was to develop structured education for patients including bite sized education which could be delivered in clinics and online.
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.

### Outpatients

#### Facts and data about this service

Outpatient services at the trust are delivered in a number of settings including the two main hospital sites, two community hospitals and GP Practices.

The outpatient clinics in GP Practices are part of Healthy Wirral agreements between NHS England, Wirral CCG, Wirral Community Trust and Wirral University Teaching Hospital Trust.

Outpatient services cover a range of routine, urgent and two-week rule cancer slots.

Most outpatient clinics are run by the outpatient department, which sits in the diagnostic and clinical support division.

However, the following specialties are responsible for their own outpatient clinics; ophthalmology, oral and maxillofacial, ear nose and throat, dermatology, and orthopaedics.

The service was open from 8.30am until 5.00pm, Monday to Friday. Extra clinics were scheduled in the evening and at weekends where appropriate.

Appointments are booked by the department’s booking and scheduling team, and the use of an automated reminder service is in place to reduce the number of patients that do not attend.

Patient feedback is reviewed monthly via Friends and Family reports.
We planned our inspection based on everything we know about services including whether they appear to be getting better or worse.

We inspected the outpatient department between 12\textsuperscript{th} and 14\textsuperscript{th} November 2019. Our inspection was unannounced. As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

We visited the main outpatient department at Arrowe Park Hospital. We also visited the booking and scheduling team, the allied health professional service, phlebotomy, cardiology clinic, fracture clinic and the ophthalmology service.

The inspection team spoke with patients, relatives and carers, members of staff including managers, consultants, nurses, clinical support workers and administrative staff. We reviewed five patient records and observed one consultation and other interactions between staff and patients.

The service was last inspected in September 2015. At the time we jointly inspected the outpatients and diagnostic services.

The trust had 466,636 first and follow up outpatient attendances from March 2018 to February 2019. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatient)
Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from March 2018 to February 2019.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of outpatient appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrowe Park Hospital</td>
<td>332,056</td>
</tr>
<tr>
<td>Clatterbridge Hospital</td>
<td>117,091</td>
</tr>
<tr>
<td>Site not specified</td>
<td>31,572</td>
</tr>
<tr>
<td>St. Catherines Hospital</td>
<td>19,518</td>
</tr>
<tr>
<td>Victoria Central Hospital</td>
<td>9,920</td>
</tr>
<tr>
<td>This Trust total</td>
<td>510,157</td>
</tr>
<tr>
<td>England</td>
<td>109,324,322</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from March 2018 to February 2019. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Wirral University Teaching Hospital NHS Foundation Trust from March 2018 to February 2019 by site and type of appointment.

(Source: Hospital Episode Statistics)

After our inspection, we requested the number of appointments cancelled by patients and number cancelled by the provider. There were 92,252 appointments cancelled by patients, this is 18% of appointments. There were 76,787 appointments cancelled by the provider, this is 15% of appointments.
Is the service safe?

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

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. Training was delivered in a mix of e-learning and face to face training.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Those staff that had not completed training had it booked into their diary. Staff could complete training during normal working hours.

Cardiopulmonary Resuscitation (CPR) training included recognising and escalating an adult / paediatric / new born / neonatal patient that is deteriorating, recognising and managing an adult / paediatric / new born / neonatal patient in cardiac arrest and perform effective CPR, recognising a choking patient and implementing appropriate treatment, use of defibrillators within cardiac arrests and equipment used within Wirral University Teaching Hospital NHS Foundation Trust and awareness of the current Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) policy.

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

Trust level

Nursing staff received and kept up-to-date with their mandatory training.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>79</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>78</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>77</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>74</td>
</tr>
<tr>
<td>Fire Safety Level 2</td>
<td>72</td>
</tr>
<tr>
<td>CPR</td>
<td>70</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>69</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>62</td>
</tr>
<tr>
<td>Data Security Awareness Level 1</td>
<td>62</td>
</tr>
</tbody>
</table>

In outpatients the 95% target was met for two of the nine mandatory training modules for which qualified nursing staff were eligible. However, during our inspection, when we spoke to the outpatient manager we identified that there were only 68 nursing staff of all grades. With this taken into account, the service was meeting targets in five mandatory training modules.

Allied health professional staff received and kept up-to-date with their mandatory training.
A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for allied health professional staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - People</td>
<td></td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td></td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td></td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Level 2</td>
<td></td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td></td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security Awareness Level 1</td>
<td></td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td></td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 95% target was met for four of the eight mandatory training modules for which allied health professional staff were eligible. However, when we discussed staffing numbers with the allied health professional directorate manager we identified that these figures were not correct. We requested the training data for allied health professionals in outpatients, however it was not possible to distinguish between inpatient and outpatient allied health professional staff. With this taken into account, the service was meeting targets in six mandatory training modules.

(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 received training specific for their role on how to recognise and report abuse. Training was provided on a rolling programme October to September each year.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service was part of a pilot within the trust to train staff to recognise and ask appropriate questions about domestic abuse.

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

Staff safeguarding training contained information for all levels of Wirral University Teaching Hospital NHS Foundation Trust staff to inform them of the procedures for reporting cases of child exploitation both internally and externally to children’s social care. Staff were encouraged to inform the safeguarding team of all actions and concerns through the electronic incident reporting system.

Staff followed safe procedures for children visiting outpatients. In Ophthalmology there were two trained safeguarding children leads, staff could explain incidents where they had escalated safeguarding concerns. In the ophthalmology service, there was a designated children’s waiting area however, at busy times, children would need to wait in adult waiting areas.

Safeguarding training completion rates

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

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

The tables below includes Protecting Vulnerable People Level two and Level three. Nurses at band four and five completed Protecting Vulnerable People Level three which included safeguarding children and vulnerable adults. Clinical support workers completed Protecting Vulnerable People Level two.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</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>
</tr>
<tr>
<td>Protecting Vulnerable People Level 3</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>71</td>
<td>75</td>
<td>94.7%</td>
</tr>
</tbody>
</table>

In outpatients the 95% target was met for one of the two safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for allied health professional staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</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>
</tr>
<tr>
<td>Protecting Vulnerable People Level 1</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>2</td>
<td>4</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

In outpatients the 95% target met for the one of the safeguarding training module for which allied health professional staff were eligible. Protecting Vulnerable People Level 1 met the trust target, however only one staff member was eligible. However, when we discussed staffing numbers with the allied health professional directorate manager we identified that these figures were not correct. We requested the training data for allied health professionals in outpatients, however it was not possible to distinguish between inpatient and outpatient allied health professional staff. The training completion rates for all allied health professional staff was; 83.74% completion rate for protecting vulnerable people level two and 93.22% completion rate for protecting vulnerable people level one.

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

**Cleanliness, infection control and hygiene**

The service did not always control infection risk well. Staff used equipment and some control measures to protect patients, themselves and others from infection. They kept the premises visibly clean.

Outpatient areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

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

There were hand gel dispensers throughout all outpatient areas with signs reminding staff, patients and visitors to wash their hands.

The service completed monthly hand hygiene audits and sent the results to the infection prevention and control team. Actions were taken when staff did not follow infection control principles.
Staff moved infectious patients, attending clinics, to a more isolated area of the department to minimise the risk of infection to others. The area would then be deep cleaned after the consultation.

Sharps bins, whilst not always closed, were labelled correctly with date, location or “locked by” information.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that staff had placed “I am clean” stickers on equipment that had been cleaned.

The service was not compliant with guidance for the decontamination of flexible nano-optic endoscopes. We observed the process for cleaning scopes which was not compliant with ‘HTM 01/06 The Safe Decontamination of Flexible Endoscopes’ because the service was decontaminating the scopes in the same room as they were scoping. HTM 01/06 states a dedicated room or area is required that can be used as a dirty/clean area. This was not in line with the trust decontamination standard operating procedure.

During our inspection we found products used for cleaning not stored securely and being used without personal protective equipment (gloves and apron) in the ophthalmology service. They were stored on the trolley in unlocked clinic rooms. We raised this with the service manager and they were removed from the clinic rooms and stored in a locked cupboard. When we asked what guidance staff used to use and store the cleaning product, the service produced only a quality audit trail record book provided by the manufacturer. They did not provide a standard operating procedure. Since our inspection the service have provided a standard operating procedure for the use of the cleaning product which states personal protective equipment should be used.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The main outpatient department was clearly labelled from the main entrance in the hospital. A new electronic board had been placed at the entrance to the department indicating where patients could check in on electronic terminals. The electronic board also displayed the clinics on that day.

The main outpatient department had a high demand for room space. There was a quiet room in the department for patients to use if they needed a quiet space or had been given bad news. However, due to demand for rooms for clinics, this room was sometimes used for a urology clinic.

The main outpatient department had nine clinic areas, each with its own waiting area, we observed there were enough seats for patients and those who attended with them to sit. However, the cardiology waiting area was shared with pre-operative assessment and could become very busy and crowded. To tackle this, the cardiology outpatient clinic offered a pager system to patients, so they could wait elsewhere. Patients were recalled back to the department as soon as the doctor or nurse was ready to see them.

In the ophthalmology department the flooring in one of the clinic rooms was in a very poor condition, it was cracked and peeling. The condition of the floor was not on the risk register. We raised this with staff during the inspection.

In the main outpatient area patient assessments were taking place in a room with a sluice hopper (a conical bowl into which waste material is poured). We inspected this room and found that the sluice hopper was in use. To minimise infection risk, staff would use the sluice hopper at the end of the clinic and disinfect the room after use. The trust infection control team had reviewed the issue and it was on the service risk register, there were controls in place whilst the service waited for it to be removed.
Staff managed clinical waste well. Staff disposed of clinical waste safely. Waste was collected in foot operated bins throughout the department.

Staff were trained to use equipment.

Staff carried out daily safety checks of specialist equipment. There were enough resuscitation trolleys on the department and a paediatric resuscitation bag with each trolley. We checked a range of equipment held in the trolleys, which were within their manufacturers’ recommended expiry dates. We saw evidence of appropriate trolley checks being carried out. The trolleys had a tamper seal. However, we found opened endotracheal tubes in the airway management tray on the ophthalmology resuscitation trolley and the defibrillator was due its service in November 2019.

The service did not consistently have enough suitable equipment to help them to safely care for patients. On the main outpatient department, we found that equipment had been regularly serviced and calibrated. However, in the ophthalmology department we found that most equipment that was in use had not been serviced, this was an issue during our last inspection. We saw five snellen charts were due to be serviced in April 2017 and one was due in August 2013, two slit lamps were due to be serviced in October 2019, two head sets were due to be serviced in October 2019, one ophthalmoscope was due to be serviced in August 2017 and one was due in August 2019, two logmor charts were due to be serviced in April 2017. We raised this with the service lead. It was not clear that the service knew who had responsibility to order the appropriate equipment checks. The trust policy stated that estates staff carried out routine inspection and testing of equipment and installations. The trust told us that it was a requirement of each area to audit their medical devices effectivity and remove from service anything that had missed the service due date. The service lead was new to post and was gathering the data of what equipment was expired and said that the equipment would be serviced.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient’s health. In the main outpatient department, clinic waiting areas were positioned so staff could see patients at all times.

Staff on the main outpatient department used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. However, nursing staff in ophthalmology told us they did not use a tool to identify deteriorating patients and escalated to the consultants on the clinic. This was not in line with the trust policy.

Staff knew what to do if a patient collapsed in the department, including calling the resuscitation team. The general outpatient department was situated next to the emergency department who could be called quickly to deal with an emergency. Whilst the fracture clinic was further away from the emergency department, staff could describe what to do in an emergency.

Staff knew about and dealt with any specific risk issues.

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

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

Staff shared key information to keep patients safe when handing over their care to others.
The service held a safety huddle at 8:30am, all necessary information to keep patients safe and to ensure smooth running of clinics was shared. This was attended by clinical support workers, nurses, nursing associates, associate nurses, students and service managers.

**Nurse staffing**

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

The service had enough nursing staff and support staff to keep patients safe.

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

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

The service had low rates of bank nurses used. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. The outpatient manager told us they used one bank nurse regularly to cover additional waiting list initiative clinics.

There was a clear induction checklist for the trust and departmental induction of new staff. The checklist detailed health and safety requirements, an overview of the divisional structure, how to access policies, and how to manage sickness absence and annual leave. The checklist allowed new starters to highlight any gaps in their knowledge during their induction.

**Trust level**

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Outpatients annual staffing metrics</th>
<th>June 2018 to May 2019</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>All staff</td>
<td>285.6</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>93.9</td>
<td>9%</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Information provided by the trust before the inspection showed there were 93.9 qualified nurses in outpatients and the trust did not report any bank or agency use in outpatients over this period. During our inspection, we were told that the main outpatients staffing establishment was 15 band five nurses, one band four nursing associate, four band four associate nurses and 46 band two clinical support workers.
Nurse staffing rates within outpatients were analysed for the past 12 months based on information provided by the trust before the inspection and indications of improvement, deterioration or change were identified in monthly rates for vacancy and sickness.

**Vacancy rates**

![Vacancy rate - qualified nurses, health visitors and midwives](chart)

Monthly vacancy rates over the last 12 months for qualified nurses show a shift from December 2018 to May 2019.

The service had low vacancy rates. During our inspection, the main outpatient department had one 20 hour band five vacancy, this had been approved to be advertised.

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

**Sickness rates**

![Sickness rate - qualified nurses, health visitors and midwives](chart)

Monthly sickness rates over the last 12 months for qualified nurses show a shift from December 2018 to May 2019.

The service had reducing sickness rates.

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

**Allied health professionals staffing**

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

**Trust level**

The table below shows a summary of the allied health professionals staffing metrics in outpatients at trust level compared to the trust’s targets, where applicable:
### Outpatients annual staffing metrics

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2018 to May 2019</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average</td>
<td>Annual vacancy rate</td>
</tr>
<tr>
<td></td>
<td>establishment (%)</td>
<td>(% of available hours)</td>
</tr>
<tr>
<td>Target</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>All staff</td>
<td>285.6</td>
<td>8%</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>3.0</td>
<td>-82%</td>
</tr>
</tbody>
</table>

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

After the inspection we asked for additional information trust regarding allied health professional input into outpatients. This showed 164.75 whole time equivalent allied health professional staff gave input into outpatients services. Staff did not raise any concerns with gaining allied health professional input when needed.

### Records

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

Records in outpatient services at Wirral University Teaching Hospitals NHS Foundation Trust were a mix of paper and electronic records.

Patient notes were comprehensive, and all staff could access them.

We reviewed five sets of patient records, two from ophthalmology outpatient clinics and three from cardiology outpatient clinics. In the ophthalmology records we found that a checklist for administration of intravitreal injection included positive patient identification, prescribed medication and written consent. In the cardiology records we found that the consultant wrote notes from the appointment into the paper records and dictated the appointment letter, which was given to the consultant secretary to type up. The notes in the paper records were not always legible and the doctors inconsistently dated and signed the records.

Records were stored securely. In main outpatients, paper records were stored in an open trolley next to the clerk desk. This desk was always staffed, and record details could not be seen by patients or visitors. During our previous inspection we found notes were left ‘face up’ on the clerk desk after patient assessments had been completed. During this visit we found that notes were now kept ‘face down’ so details could not be seen by patients or visitors. In ophthalmology, and in more busy, clinical areas, a lockable records trolley was used.

There was a clear process for staff to follow to ensure that records were ready for clinics. 3% of outpatient patients were seen without their full medical record being available. Medical records for clinic appointments were collected from secure medical record storage by the administration team. The administration team would check the referral letter was available and results were up to date in preparation for the clinic.

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

Staff stored and managed medicines and prescribing documents in line with the provider’s policy.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Medicines in ophthalmology were stored safely and securely within locked metal medicine cabinets and a locked fridge. A limited stock of medicines was kept, and this was topped up by the pharmacy team who also monitored expiry dates. No controlled drugs were stored in the department.

During our last inspection, eye drops were not stored securely in ophthalmology. During this inspection we found that eye drops were now stored in locked storage lockers in clinic rooms.

Prescribing documents were locked in a storage locker on the ophthalmology department. The nurse and consultant would sign to denote the number of prescriptions issued so there was an auditable trail. The service used outpatient prescriptions rarely, they were kept in a metal locked cupboard.

Medicines fridge temperatures were appropriately monitored with a record of minimum or maximum temperatures and a record of the room temperature.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Between July 2018 and June 2019, a total of 445 incidents were recorded across the service. The majority of incidents, 427, resulted in no or low harm to patients, visitors or staff, or were classified as a 'near miss'.

The service reported 18 incidents which resulted in moderate harm to patients, visitors or staff. The top three common themes of patient, visitor and staff incidents were related to slips, trips and falls, and staffing levels.

Staff knew what incidents to report and how to report them. Staff could give examples of incidents that they had reported, for example, if a clinic overran by an hour, staff would incident report it.

Staff raised concerns and reported incidents and near misses in line with trust policy.

The service used incidents to improve its service and there was evidence that changes had been made because of feedback.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The service met the regulation requirements of duty of candour by notifying the relevant person that the incident occurred and providing support to the person.

Managers debriefed and supported staff after any serious incident. Managers investigated incidents thoroughly.

Staff received feedback from investigation of incidents in the service.

Staff met to discuss the feedback and look at improvements to patient care.
Managers shared learning with their staff about never events that happened elsewhere through the daily safety huddle.

**Never Events**

The service had no never events on the department.

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 July 2018 to June 2019, the trust did not report any never events for outpatients.

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

**Breakdown of serious incidents reported to STEIS**

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from July 2018 to June 2019.

*(Source: Strategic Executive Information System (STEIS))*
Is the service effective?

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff could access the policies on the trust intranet.

The service used local policies, protocols and patient pathways. We reviewed a number of these including the national early warning score policy, control of substances hazardous to health and safeguarding adults’ procedure and guidance. The documents were based on up-to-date evidence and best practice and referenced guidance from the National Institute of Health and Care Excellence (NICE) and professional bodies.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Nutrition and hydration

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. There were water dispensers available in main outpatients.

Staff would conduct an hourly comfort check in waiting areas to ask patients if they needed a drink or something to eat and update them of any waits in clinic.

The cardiology clinic offered a pager system (an electronic buzzer that vibrated when it was time for the patient to see a doctor) to patients who wanted to leave the department for refreshments if there was a delay in clinic. Patients were recalled back to the department as soon as the doctor or nurse was available to see them.

There was a small coffee shop located next to the electronic signing in kiosks at the main outpatient entrance where patients, staff and visitors could purchase drinks and snacks. In ophthalmology there were vending machines available for patients to purchase snacks.

We saw there was a hypo (hypoglycaemia) box available which contained energy drinks and glucose tablets for patients who may have a hypo. Hypoglycaemia is when your blood glucose level (also called blood sugar) is too low.

Specialist support from staff such as dieticians was available for patients who needed it.

Patient outcomes

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

The service had a system it used to monitor referral to treatment times, ‘did not attend’ rates, and clinic cancellations. These lists were discussed at weekly access and performance meetings. The service also monitored medical record availability. Information was cascaded to individual teams.

Managers and staff carried out a programme of repeated audits using an audit app that was used across the trust to check improvement over time. Managers shared and made sure staff understood information from the audits.
Managers used information from the audits to improve care and treatment. Improvement was checked and monitored.

**Follow-up to new rate**

From 01 March 2018 to 28 February 2019,
- the follow-up to new rate for Victoria Central Hospital was lower than the England average.
- the follow-up to new rate for Arrowe Park Hospital, Clatterbridge Hospital, St. Catherines Hospital and trust level (site not specified) was higher than the England average.

**Follow-up to new rate, Wirral University Teaching Hospital NHS Foundation Trust.**

(Source: Hospital Episode Statistics)
Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

From April 2018 to March 2019, 87.3% of required staff in outpatient services received an appraisal compared to the trust target of 88%.

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health Professionals</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>101</td>
<td>113</td>
<td>89.4%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>70</td>
<td>82</td>
<td>85.4%</td>
<td>88.0%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>63</td>
<td>75</td>
<td>84.0%</td>
<td>88.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Information provided by the trust before the inspection showed that registered nursing staff appraisal rates were at 85.4% with 70 out of 82 staff recorded as receiving an appraisal. During our inspection, we were told that the main outpatients current nursing staff appraisal completion rate was 87.5% with 14 out of 16 registered nurses recorded as receiving an appraisal. In main outpatients, 100% of unregistered nurses, which was 50 staff members, had received an appraisal.

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

Patients could see all the health professionals involved in their care at rapid access clinics. For example, patients attending the stroke rapid access clinic were given one appointment and would be seen by a number of different specialties (for example diagnostics) on the same day. This helped reduce hospital visits.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Seven-day services

The trust did not provide a seven-day outpatient service, although clinics could be arranged for evening and weekends when appropriate.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in waiting areas.

The main outpatient department had numerous leaflets that provided patients with additional information. This included, amongst other things, infection prevention, lung health and diabetes during pregnancy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed doctors and nurses obtaining verbal consent before examining patients.

Staff clearly recorded consent in the patients’ records when appropriate, most consent in main outpatients was informed verbal consent. In ophthalmology written consent was recorded in patient records before the procedure such as the administration of intravitreal injection.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.
Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Mental Capacity Act and Deprivation of Liberty Safeguards training was included within the protecting vulnerable people training. Nurses at band four and five completed Protecting Vulnerable People Level three which had a 100% completion rate. Clinical support workers completed Protecting Vulnerable People Level two which had a completion rate of 94.7%.

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

Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. Patients we spoke with were positive about staff, stating 'staff have always been lovely' and that staff were 'respectful'.

Staff followed policy to keep patient care and treatment confidential. The service had electronic checking in kiosks which meant patients could check-in without having to discuss personal information. Receptionists were still available for those patients that did not want to use the electronic kiosks. Patients we spoke with were happy to use the electronic kiosks and found them easy to use.

Patients could request chaperones. There were signs informing patients of the chaperone service in the waiting areas we viewed. Staff told us that patients usually asked if they wanted a chaperone.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity.

There was a quiet room within the main outpatient department that patients and relatives could use if they received upsetting news. Staff told us they would take patients to the quiet room if they became distressed. However, we were told this room was used on occasion as a clinic room during busy clinic days.

Staff were able to give examples of providing additional support for individual patients.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.
Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

**Understanding and involvement of patients and those close to them**

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The patients we spoke with told us that they had time to discuss their concerns and did not feel rushed, even if a clinic was running over time.

When we asked about availability of leaflets with information, one patient told us ‘I don’t need leaflets as everything is explained’.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service. Patients told us ‘they always see me quite quickly, I’m not waiting around for long’ and ‘they always tell us if they’re running late.’

Staff told us that patients received a friends and family text questionnaire after their appointment. Patient feedback was reviewed monthly from the friends and family reports. Themes were cascaded to staff and improvements had been made within the department based on this feedback.

We observed one consultation. The doctor reviewed the patients’ past medical history, conducted an examination of the nose using the nano-optic endoscope and examined the throat. The doctor communicated with the patient throughout explaining each stage of the examination and gaining informed consent.

**Is the service responsive?**

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

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

Facilities and premises were appropriate for the services being delivered.

The main outpatient department was clearly labelled from the main entrance in the hospital. A new electronic board had been placed at the entrance to the department indicating where patients could check in on electronic terminals. The electronic board displayed the clinics on that day. The service had volunteers to help patients use the electronic kiosks and to find the department.

During our inspection, we did not observe a hearing loop at the ear, nose and throat clinic.

Staff conducted hourly comfort checks to offer patients refreshments and explain current waiting times. However, waiting times were not always displayed in waiting rooms for patients to see.

The trust's website had a section dedicated to its outpatient service. This provided useful information to patients and those accompanying them. It explained the steps patients would follow when visiting and the opening times.
Service leads told us there was a trust-wide matron hotline telephone number, this number was given to patients and their relatives, so they could speak to a matron in the trust if they had any concerns.

The service was planned and organised so it met the changing needs of the local population. The service gave patients information that was relevant to their outpatient appointment in their appointment letter, such as the need to bring samples. However, it was not clear if clinics that may take a long time, such as ophthalmology, made this clear in their letter to patients.

Since our last inspection, the ophthalmology department had recruited an eye clinic liaison officer. They would provide support to patients with new diagnosis’ and help patients with finances, acquiring equipment and work with patients about to go on the register of people who were either severely sight impaired (blind) or sight impaired (partially sighted). The service had also put a pack together of useful information for patients who were discharged with Macular Disease.

The service had an electronic booking system available for patients to book their appointment up to six weeks in advance. The service had plans to allow this system to show more than the six week availability so patients could see how long the wait for an appointment may be. The service had a target of mid-December to complete this.

The service offered evening and weekend clinics for patients who could not access the daytime clinics.

Staff could access emergency mental health support for patients with mental health problems, learning disabilities and dementia. Staff we spoke to gave examples of when they had used these services.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had access to a disability link nurse who would help staff plan support for patients in need of additional support.

The outpatient department was situated close to two coffee shops in the hospital main entrance and outpatient department entrance where patients could purchase refreshments. One café was open Monday to Friday 8:15am to 9:00pm and Saturday and Sunday 11:00am to 9:00pm.

**Did not attend rate**

From 01 March 2018 to 28 February 2019, the ‘did not attend’ rate for; Arrowe Park Hospital, St. Catherines Hospital, Victoria Central Hospital, and trust level (site not specified) was higher than the England average.

The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, Wirral University Teaching Hospital NHS Foundation Trust.**
The service monitored and took action to minimise missed appointments. The service used an automated reminder service to reduce the number of patients that did not attend.

At the time of inspection, managers did not ensure that patients who did not attend appointments were contacted. The service was in the process of changing the did not attend policy. During the inspection, the policy was that patients were given another appointment if they did not attend. The lead for referral to treatment times told us the new policy included a 14-day letter to be issued to the patient who did not attend requiring them to respond and re-book their appointment within 14 days should it still be required. If the patient did not respond within 14 days, they would be discharged back to their GP. Service leads told us they would speak to the consultant first before discharging the patient in case there were additional needs to consider. If additional needs were identified, they would work with the GP to establish why the patient did not attend and contact the patient to re-book.

**Meeting people’s individual needs**

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

The general outpatient area had a quiet room for those patients that were anxious, had autism, or were living with dementia, and wanted to wait in a quieter area. The clinics usually had advanced notice of a patient with autism or dementia attending an appointment and would look to prioritise these patients in the clinic list to avoid delays.

The department was designed to meet the needs of patients living with dementia. We observed dementia friendly signs and toilet facilities in the outpatient department.

The trust provided a pre-bookable volunteer assistant service for patients or visitors who needed assistance to a specific area for their hospital appointment. A wheelchair could also be provided if required. The service was available Monday to Friday between 9am and 4pm at Arrowe Park Hospital.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.
Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed.

Staff had access to communication aids to help patients become partners in their care and treatment.

**Access and flow**

**People requiring routine treatment could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national expectations.**

Data showed that, for a number of specialties, the outpatient department was below the England average for seeing patients within 18 weeks of referral. These specialities included oral surgery, urology and trauma and orthopaedics. The service had systems in place to review waiting lists (a weekly access and performance meeting chaired by the head of business improvement) to ensure that those patients that required an urgent appointment could be escalated and seen quickly.

The electronic booking system did not give patients an indicative wait time for the service. This was something the scheduling and booking team were aiming to implement to help the patient to choose which hospital they wanted to attend based on waiting times.

Managers monitored waiting times and had a process in place to identify patients that might be at risk due to not having access to services when needed and not receiving treatment within agreed timeframes and national targets.

The trust had a process in place to identify patients that might deteriorate whilst waiting longer than 18 weeks. This risk was identified on the risk register and controls were put in place to mitigate the risk of a patient deteriorating whilst waiting. Within urology, these controls included consultants reviewing and triaging routine referrals.

The trust target for referral to treatment times was 80% with a wait list of no more than 24,736 and no 52 week breaches. The trust provided evidence that in October 2019 referral to treatment times was 79.03% with 24,368 on the open pathway waiting list and zero 52 week breaches, however the 18 week wait for appointments were still above the England average.

Appointments were sent out by letter. Staff we spoke with told us that patients could rearrange appointments for times that better suited them. Patients were also sent a text reminder in advance of the appointments to try and avoid non-attendance.

When patients had their appointments cancelled at the last minute, the booking and scheduling team made sure they were rearranged as soon as possible and within national targets and guidance.

The service had undertaken a number of waiting list initiatives including weekend and evening clinics. As part of the transformation improvement work, the service was looking to run virtual clinics where consultants could spend time reviewing patient files to see if a patient still needed to be on the waiting list, or if it would be more appropriate to refer them to other services.

Patients that required a follow up appointment within six weeks were booked an appointment before they left the clinic. Patients that required an appointment after six weeks were placed on a request queue in date order of appointment due. It was the trust policy to book up to six weeks ahead to prevent patients being cancelled due to clinical leave. The service team were notified by the booking clerks of patients that fell out of the expected due date and escalated to the responsible clinician for review and guidance.
The trust told us it had processes in place for recording and tracking follow up patients. They completed a lost to follow up audit which was presented to the local clinical commissioning group (CCG) and NHS England. The service leads told us they were assured that they did not lose any patients to follow up.

Managers worked to keep the number of cancelled appointments to a minimum. The Musculoskeletal (MSK) service had a referral triage system which allowed the service to increase clinic utilisation by ensuring that referrals were right first time and to help avoid cancellations and inappropriate diagnostic referrals.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From June 2018 to May 2019 the trust’s referral to treatment time (RTT) for non-admitted pathways has been consistently lower than the England overall performance. The latest figures for May 2019, showed 73.5% of this group of patients were treated within 18 weeks versus the England average of 87.6%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Wirral University Teaching Hospital NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Three specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>95.4%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>92.0%</td>
<td>83.5%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>80.7%</td>
<td>80.1%</td>
</tr>
</tbody>
</table>

Twelve specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>88.2%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Other</td>
<td>81.2%</td>
<td>89.8%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>80.4%</td>
<td>88.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>79.4%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>77.8%</td>
<td>87.8%</td>
</tr>
</tbody>
</table>
Rheumatology | 76.0% | 86.0%
General Medicine | 75.0% | 90.8%
Cardiology | 73.7% | 85.4%
Gastroenterology | 71.1% | 81.0%
Thoracic Medicine | 69.3% | 85.9%
Trauma & Orthopaedics | 65.3% | 85.6%
Urology | 60.6% | 84.4%

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From June 2018 to May 2019 the trust’s referral to treatment time (RTT) for incomplete pathways has been consistently lower than the England overall performance. The latest figures for May 2019, showed 80.7% of patients awaiting treatment had been waiting less than 18 weeks versus the England average of 86.4%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Wirral University Teaching Hospital NHS Foundation Trust.

(Source: NHS England)

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

One specialty was above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>88.7%</td>
<td>87.9%</td>
</tr>
</tbody>
</table>

One specialty was the same as the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>95.8%</td>
<td>95.8%</td>
</tr>
</tbody>
</table>

Fourteen specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>87.9%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Other</td>
<td>86.2%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>83.5%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>83.4%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>81.4%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>80.4%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>80.1%</td>
<td>89.5%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>78.7%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>72.6%</td>
<td>86.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>72.1%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>71.7%</td>
<td>81.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>71.2%</td>
<td>84.8%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>60.0%</td>
<td>82.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing above the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Wirral University Teaching Hospital NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers) - Wirral University Teaching Hospital NHS Foundation Trust

The trust is performing above the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing above the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Wirral University Teaching Hospital NHS Foundation Trust

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas and on the trust website. There were posters and leaflets throughout the main outpatient department explaining how patients could raise a concern or complaint.

Staff understood the policy on complaints and knew how to handle them.
Managers investigated complaints and identified themes. The outpatient manager had a regular meeting with the patient experience team to discuss themes in complaints and to make improvements.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. During our inspection we reviewed one complaint. When writing to the complainant the associate director of nursing for diagnostics and clinical support had explained the measures put in place since their complaint and referred them to the Health Service Ombudsman if they were not satisfied with the response.

Staff told us that conducting the hourly comfort check had reduced the number of complaints they received. This was because patients were kept updated on clinic waiting times and offered refreshments.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

**Summary of complaints**

**Arrowe Park Hospital**

From July 2018 to June 2019 there were 10 complaints about outpatients at Arrowe Park Hospital. The trust took an average of 29 days to investigate and close complaints, this was in line with their complaints policy, which states complaints should be investigated and close complaints within 30 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment &amp; Procedure</td>
<td>3</td>
<td>30.0%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>2</td>
<td>20.0%</td>
</tr>
<tr>
<td>Access &amp; Admission</td>
<td>2</td>
<td>20.0%</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
<td>10.0%</td>
</tr>
<tr>
<td>Patient Slip Trip or Fall</td>
<td>1</td>
<td>10.0%</td>
</tr>
<tr>
<td>Documentation</td>
<td>1</td>
<td>10.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</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**

From July 2018 to June 2019 there was one compliment about outpatients at Arrowe Park Hospital.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The main outpatient service was delivered within the trust’s diagnostics and clinical support division. Main outpatients had been managed within this division for over 10 years. However, the following specialties were responsible for their own outpatient clinics; ophthalmology, oral and maxillofacial, ear nose and throat, dermatology, and orthopaedics.

The diagnostic and clinical support division was led by an associate medical director, associate director of nursing and divisional director. These three senior staff worked together to ensure the smooth running of the division across medical, nursing and operational aspects.

The leaders of the main outpatient department had appropriate skills, knowledge and experience to lead the service, and were able to describe the leadership and reporting structure for their teams. They understood issues, challenges and priorities in their service. When we asked staff from other specialties, they were able to describe the leadership and reporting structure for their own division, such as surgery.

The leadership team was supported by a band seven outpatient manager, and two part time band six deputy managers.

Staff on the department spoke positively about their local leaders, who they considered were visible on the unit, approachable and supportive. However, there was less visibility of executive staff on the unit.

In the ophthalmology service, the unit sister was new to post having been promoted from the deputy role. The service was about to go out to advert for the vacant deputy role. This meant the unit sister was doing two roles.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The outpatient service had a vision to ensure ‘Value at Every Encounter’. Value for the patient, the clinician(s) and the trust. Value for the patient, the aim was to ensure that they are provided with the diagnosis, treatment, or information that they need. Value for the clinician, the aim was to ensure that every time they see a patient, they had the information and time they needed to provide a quality clinical encounter. Value for the Trust, the aim was to ensure a high quality, clinical encounter, with no waste of resource and which resulted in positive patient experience/feedback.

The approach to this improvement was structured by the outpatient transformation group. This group had identified four project areas to improve the outpatient service. ‘21st century outpatients’, ‘High Value First Appointments’, ‘Enhanced Communication’, and ‘Consistent Framework’. The four project areas had an identified lead and a detailed plan developed for each, with a view to develop the clinical reference group.
They planned to achieve these four project areas by; developing the belief that change can happen among the different specialities; specialty and service led redesign and modernisation; facilitate change through IT; and develop clear plans, with accountability and milestones.

**Culture**

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

All staff we spoke with told us they enjoyed working at the hospital and in their teams. They told us that colleagues were supportive, with good team work between doctors, nurses, support staff and clinical support workers. Most staff told us there was a good culture at the trust.

We spoke with medical, nursing, health care support, administration and domestic staff throughout the service. All staff we asked spoke positively about the culture within the service, and in their cross-team interactions with other clinical staff. Staff felt proud to work for the service.

Service managers for ophthalmology told us the culture on the unit had improved since the last inspection. The ophthalmology department had won ‘Team of the Year’ at the trust ‘Together We Will’ award ceremony. Staff were very proud of the improved culture in their team.

The trust had freedom to speak up guardians.

Staff told us there was an open, no blame culture and they felt confident to raise any concerns with their managers. Staff felt respected by all grades and demonstrated teamwork during the inspection.

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

Staff told us that they were given feedback on positive responses from the friends and family test. Thank you cards from patients were displayed in the staff room.

**Governance**

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

Management processes were in place to ensure there was escalation and the cascading of information to and from the senior management team to frontline staff. All staff were able to describe the structure and understood their role and responsibilities and the role of others.

The booking and outpatients department had a monthly clinical governance meeting. The agenda included reviewing the risk register, incidents reported about booking and outpatients, health and safety and infection control issues and was attended by the divisional quality and governance lead, outpatient manager and booking office manager. This meeting fed into the divisional diagnostics and clinical support meeting. Actions were assigned to individuals and deadlines given. When reviewing the minutes, we noted that the meetings were going to be bi-monthly from November.

Senior managers from the division of diagnostics and clinical support attended monthly divisional clinical support meetings. The agenda included risk, staff engagement, incidents, feedback from divisional areas and audit. Actions were assigned to individuals and deadlines given.

**Management of risk, issues and performance**
Leaders and managers used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Leaders had a clear understanding of the risks for the outpatient department including: staffing levels and a lack of capacity in the clinics.

Each department that had an outpatient service had a risk register. Any risks that were new or scored nine or above would be discussed at the divisional governance meeting for approval and then added to the risk register. Any risk scored 12 or above would be discussed at the risk management committee. The main outpatient department reviewed their risks weekly with the outpatient manager and governance lead.

When we reviewed the risk register we found that risks did not have a date for when they were added to the register. The risk register detailed the principle risk, controls in place and an action plan summary. Each risk had evidence that it had been reviewed and had a review date set and had a risk owner assigned.

We reviewed the minutes of the divisional governance meeting and risks were discussed, closed and new risks added. The new risk was given a level and decided if it was a valid risk, actions and controls were then agreed. When a risk was reduced due to controls and actions, it was closed.

The service had implemented an electronic audit application which supported ongoing department improvement through a continuous improvement model. Managers were able to inspect and audit using the application across clinical areas, including hand hygiene. The continuous Improvement model provided the department with the opportunity to benchmark themselves against an agreed standard and make required improvements.

Information management

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

Records in outpatient services were a mix of paper and electronic records. Some consultant led clinics dictated notes and these were transcribed by the secretarial staff.

Patient notes were comprehensive, and all staff could access them however, it was difficult to know whether information was stored in the paper records or electronic records. This meant it was not always easy for staff to find information quickly. Staff told us they could always gain access to a computer to access records or the intranet.

The trust told us before our inspection that withdrawal of paper records was planned for outpatients by December 2019 making the records fully electronic. When we asked staff about moving to electronic records, they were not aware of a deadline for this.

Records were stored securely. However, in main outpatients, paper records were stored in an open trolley next to the clerk desk. This desk was always staffed, and record details could not be seen by patients or visitors.

Guidelines and policies for outpatients were stored on the intranet for easy access for staff.

There was a shared electronic patient record system across Wirral that local GPs and the trust could access. The shared care record provided access to real time patient information.

The trust had plans to introduce a patient portal, which would allow patients to access information relevant to their care. Patients would be able to see confirmed appointments that had been
scheduled, test results (specific tests were selected through consultation with GPs, consultants and specialist nurses which would be most beneficial for this platform), discharge summaries and clinic letters would be available to the patient. A new initiative was being developed to launch the musculoskeletal (MSK) service on the portal to support patients to self-care and avoid having to come back to hospital for further appointments.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Within main outpatients, patients were sent a text questionnaire about their experience. This feedback was then discussed bi-weekly with the outpatient manager and corporate nursing to identify themes and trends and make improvements to the service. Staff could demonstrate changes that had been made based on this feedback.

Senior leads told us the service recently engaged with all clinical specialities that provided an outpatient service to look at improvements for outpatient service design. Good practice throughout outpatients and examples of good practice from other trusts were pitched and clinicians asked to reflect and feedback on what they wanted to include in the improvement plan.

Senior leads told us they involved the local clinical commissioning group and patients in the development of the improvement plans for outpatients as part of the transformation portfolio. Patients were involved through feedback workshops. The divisional director also attended a local planned care board to engage with local services and the local clinical commissioning group.

The musculoskeletal (MSK) service met with local GP’s regularly to discuss the service.

Learning, continuous improvement and innovation

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

In the ophthalmology service, there were plans to train clinical support workers to take on appropriate tasks from nurses. This would develop the staff and support staffing challenges. The service was aiming to have a consultation with clinical support workers about this and was writing the competency framework needed.

The trust had a transformation portfolio which focused on improvement initiatives including the trust’s three priority programmes; patient flow improvement, perioperative medicine improvement and outpatients improvement programme. The outpatient improvement programme was supported by the service improvement team and a quality improvement team which had undertaken quality, service improvement and redesign training. They provided advice, guidance and shared appropriate tools to support teams.

The service held a ‘The Future of Wirral Outpatients’ workshop in October 2019 that looked at 21st century outpatient practices using technology with all specialities to share good practice. The aim of the day was to share what different specialities were already doing and ideas from other trusts. Specialities were then asked to decide what transformation initiatives they would like to implement.

The service had worked with other organisations to see how they could improve their own services. For example, they had visited another hospital that used the same electronic record system to see how they had implemented the use of electronic room booking solutions.
During our inspection, the allied health professional directorate held a ‘Good Practice Day’ for all staff to attend from the acute and community trust. The aim was to share good practice and widen understanding of the different allied health professional services offered as well as showcasing research into service improvement.

Wirral University Teaching Hospital NHS Foundation Trust

Evidence appendix
Arrowe Park Hospital
Arrowe Park Rd
Upton
Birkenhead
Wirral CH49 5PE

Date of inspection visit:
8 October to 14 November 2019

Date of publication:
31 March 2020

Tel: 0151 678 5111
https://www.wuth.nhs.uk/

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

Diagnostic imaging

Facts and data about this service

Diagnostic imaging services at the trust are delivered across the two main hospital sites, Arrowe Park Hospital and Clatterbridge Hospital and in two community hospitals (St Catherine’s and Victoria Central Hospital).

We only inspected the diagnostic imaging service at Arrowe Park Hospital during this visit.

A comprehensive range of diagnostic services are provided including x-ray, CT, MRI, ultrasound, interventional radiology and fluoroscopy. The Trust runs a 24/7 on-call interventional and general radiology on-call.

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

Activity
Between November 2018 and October 2019, the trust’s diagnostic imaging service completed:

- 49940 routine and 6355 urgent general X-ray examinations
- 763 routine and 202 urgent musculoskeletal X-ray examinations
- 18299 routine and 1749 urgent ultrasound scans
- 242 routine and 14 urgent musculoskeletal ultrasound scans
- 2951 routine and 1802 urgent CT scans
- 2861 routine and 463 urgent MRI scans
- 1519 routine and 103 urgent musculoskeletal MRI scans.

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

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

The mandatory training was comprehensive and met the needs of patients and staff.

The radiology service manager monitored mandatory training and alerted staff when they needed to update their training.

Allied health profession staff received and kept up-to-date with their mandatory training.

Radiologist staff received and kept up-to-date with their mandatory training.

**Mandatory training completion rates**

The trust set a target of 95% for completion of mandatory training. It was not possible to disaggregate training figures provided by the trust prior to the inspection to site level; therefore, we have reported the training figures at trust level.

**Trust level**

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified allied health professionals in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>114</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>113</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>112</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>101</td>
</tr>
<tr>
<td>Fire Safety Level 2</td>
<td>100</td>
</tr>
<tr>
<td>CPR</td>
<td>100</td>
</tr>
</tbody>
</table>
In diagnostic imaging the 95% target was met for one of the eight mandatory training modules for which qualified allied health professionals were eligible.

At the time of inspection, mandatory training completion rates for allied health professional staff at Arrowe Park only is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>91</td>
<td>93</td>
<td>97.9%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>92</td>
<td>93</td>
<td>98.9%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>92</td>
<td>93</td>
<td>98.9%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>72</td>
<td>93</td>
<td>77.4%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety Level 1</td>
<td>93</td>
<td>93</td>
<td>100%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>CPR</td>
<td>83</td>
<td>93</td>
<td>89.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention Level 2</td>
<td>83</td>
<td>93</td>
<td>89.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security Awareness Level 1</td>
<td>87</td>
<td>93</td>
<td>93.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Post inspection additional data request DR131)

At the time of the inspection, which was mid-way through the yearly reporting period, mandatory completion rates for allied health professionals had improved. The trust’s 95% target was met for four of the eight mandatory training modules; however, completion rates were high for the majority of modules and it was expected that the target would be met by the end of the reporting period. There were systems and processes in place for identifying which staff had yet to complete required training.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for radiologist staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety Level 1</td>
<td>19</td>
<td>20</td>
<td>95.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention Level 2</td>
<td>17</td>
<td>20</td>
<td>85.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling – Object</td>
<td>17</td>
<td>20</td>
<td>85.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>17</td>
<td>20</td>
<td>85.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>16</td>
<td>20</td>
<td>80.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>CPR</td>
<td>12</td>
<td>20</td>
<td>60.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Data Security Awareness Level 1</td>
<td>11</td>
<td>20</td>
<td>55.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>10</td>
<td>20</td>
<td>50.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling – People</td>
<td>4</td>
<td>20</td>
<td>20.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

In diagnostic imaging the 95% target was met for one of the nine mandatory training modules for which medical staff were eligible.

At the time of inspection, mandatory training completion rates for radiologist staff at Arrowe Park only is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>19</td>
<td>21</td>
<td>90.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
At the time of the inspection, which was mid-way through the yearly reporting period, mandatory completion rates for radiologist staff had improved. The trust’s 95% target was met for two of the eight mandatory training modules; however, completion rates were high for the majority of modules and only narrowly missed the trust’s target due to the comparatively low number of eligible staff in the group. There were systems and processes in place for identifying which staff had yet to complete required training.

Safeguarding

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

Allied health professional and radiologist staff received training specific for their role on how to recognise and report abuse. The training included awareness of female genital mutilation, child sexual exploitation, and awareness of the anti-radicalisation Prevent duty.

Staff could give examples of how to protect patients from harassment and discrimination.

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

Staff knew who to inform if they had concerns, and how to contact the trust’s safeguarding team for advice.

Staff followed safe procedures for children visiting the unit.

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training. It was not possible to disaggregate training figures provided by the trust prior to the inspection to site level; therefore, we have reported the training figures at trust level.

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified allied health professionals in diagnostic imaging is shown below:

(Source: Routine Provider Information Request (RPIR) – Training tab)
In diagnostic imaging the 95% target was not met for the protecting vulnerable people level two safeguarding training module for which allied health professional staff were eligible for the period April 2018 to March 2019.

At the time of inspection, mandatory training completion rates for allied health professional staff at Arrowe Park only is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>82</td>
<td>93</td>
<td>88.2%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Post inspection additional data request DR131)

At the time of the inspection, which was mid-way through the yearly reporting period, mandatory completion rates for allied health professional staff had improved. The service had not yet met the trust’s 95% target for level two training. However, there were systems and processes in place for identifying which staff had yet to complete required training.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>19</td>
<td>20</td>
<td>95.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

In diagnostic imaging the 95% target was met for the protecting vulnerable people level two safeguarding training module for which radiologist staff were eligible for the period April 2018 to March 2019.

At the time of inspection, mandatory training completion rates for radiologist staff at Arrowe Park only is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>18</td>
<td>21</td>
<td>85.7%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Post inspection additional data request DR131)

At the time of the inspection, which was mid-way through the yearly reporting period, mandatory completion rates for allied health professional staff had marginally deteriorated. The service had not yet met the trust’s 95% target for level two training for radiologist staff; however, completion rates were high and it was expected that the target would be met by the end of the reporting period. There were systems and processes in place for identifying which staff had yet to complete required training.

**Cleanliness, infection control and hygiene**

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The areas we visited, including waiting areas and scanning rooms, were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.
Staff mostly followed infection control principles including being ‘arms bare below the elbow’, washing hands and in the use of personal protective equipment (PPE) when appropriate. However, we observed that one staff member in the CT unit did not wash their hands between three consecutive patients.

Hand hygiene audits were undertaken weekly in the diagnostic imaging service. Between 19 November 2018 and 18 November 2019, the radiology service at Arrowe Park was compliant with hand hygiene on all weeks where the audit was submitted (nine weeks were not submitted). For ultrasound services, for the same period, the service was compliant on all weeks except one where data was submitted; the service did not submit data in two weeks during the period.

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

The service had a standard operating policy for cleaning of ultrasound probes. This detailed a three step process to achieve high level disinfection using a product that provided sporicidal, mycobactericidal, virucidal, fungicidal and bactericidal protection.

Environment and equipment

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

Each modality had its own waiting area, which included sufficient seating for patients and their carers. The waiting areas were visibly clean and appeared to be appropriately maintained. Information boards displayed relevant information.

We observed one wooden toy in the main X-ray department’s waiting area, but there did not appear to be any other child-friendly elements in the waiting areas for children. However, the X-ray department was co-located to the children’s emergency department. This meant that child patients could remain within the emergency department’s paediatric area until they were ready to be scanned.

The service had enough suitable equipment to help them to safely care for patients. However, the service’s leaders acknowledged that the majority of diagnostic imaging equipment in the department was approaching, or had exceeded, the end of its manufacturers’ recommended life-spans.

Staff carried out daily and monthly quality assurance safety checks of specialist equipment. This included daily automated calibration of scanning equipment. Maintenance contracts were in place to ensure all diagnostic imaging equipment was regularly serviced, calibrated and maintained, and repairs carried out when necessary. We viewed service records for a range of scanning equipment, which confirmed these regular checks were being carried out. The service had recently replaced one of its MRI scanners.

The age of the diagnostic imaging equipment was a recorded risk at service, divisional and trust level. As part of this, all diagnostic imaging equipment in the department had been risked assessed to determine priorities for the service’s equipment replacement programme. The equipment replacement programme depended on agreement of capital expenditure by the hospital; therefore, although service leaders were able to describe which pieces of equipment were due to be replaced first, there were no firm timescales in place for this at the time of the inspection.

Equipment, including patient trolleys, within the MRI unit was labelled as ‘MRI Safe’ or ‘MRI Not Safe’ depending on whether or not it could be used within the MRI scanning rooms. We identified one drip stand that had been labelled with coloured tape instead of a label. Staff told us that red and
blue tape indicated the equipment was MRI safe; however, we were not assured this was widely known. We raised this with staff at the time to arrange for appropriate labels to be used.

The service’s leaders told us, for interventional radiology, the availability of recovery beds was a concern; this had the potential to lead to cancellation of a procedure if a bed was not available for the patient.

Staff disposed of clinical waste safely. Clinical waste was segregated. Sharps bins on the unit were observed to not be over-filled and were part-closed.

However, we observed that a sluice room and a cleaning cupboard located just inside the CT/Ultrasound department and easily accessible from the main hospital corridor, were unlocked. The cleaning cupboard included a range of cleaning equipment and products. This is not in line with evidence-based practice and requirements of the control of substances hazardous to health. We raised this with the CT lead radiographer at the time.

At the time of our inspection, a minor roof leak was observed just outside the X-ray department. Staff told us the estates team were aware of the leak, which had been appropriately cordoned off with warning signs.

**Assessing and responding to patient risk**

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

The trust contracted an external organisation to provide radiation protection advisers and medical physics experts which supported the diagnostic imaging services. In turn, the department had 12 radiation protection supervisors; these were staff who were responsible for ensuring compliance with the Ionising Radiation Regulations 2017 (IRR) and Ionising Radiation Medical Exposure Regulations, IR(ME)R, in areas which are subject to local rules. Local rules summarise the key working instructions intended to restrict exposure in radiation areas. Local rules were in place for each of the diagnostic imaging modalities; we saw evidence that staff had signed to confirm they had read the documents.

The Ionising Radiation Medical Exposure Regulations, IR(ME)R require a number of procedures to be in place within every department that uses ionising radiation. These cover a wide range of patient safety features such as patient ID, checking pregnancy and dose recording. We observed staff undertaking these checks with patients and visitors during our visit.

Referrals to the diagnostic imaging department were electronic. All referrals to the diagnostic imaging service were vetted for appropriateness of the referral and to check that exposure was justified. The department held a non-medical referrers file which detailed non-medical staff who had received training and were eligible to make a referral into the service.

Staff completed risk assessments for each patient on arrival. Staff shared key information to keep patients safe when handing over their care to others. Each modality had safety questionnaires that patients were required to complete on arrival. The questionnaires asked for a range of information including checks on the potential pregnancy status for patients of child-bearing age.

We observed staff following the pause and check protocol before commencing with scans. However, from our observations, we were not assured that staff consistently checked allergy status with patients and were, on occasions, relying solely on allergy status recorded on the patient electronic record system. As allergy status could potentially change, it would be good practice to verbally check the information held was still correct.
There were clear illuminated signs outside each of the rooms in the diagnostic imaging department informing patients, visitors and staff where radiation exposures were taking place. Information posters relating to potential pregnancy were also displayed in the department.

Sufficient lead aprons and collars were available for staff in all areas where there was a potential for radiation exposure. A process was in place for visibly checking these for any signs of damage or deterioration; X-ray imaging of the personal protective equipment was undertaken to check its integrity if there were any signs of damage.

Staff wore radiation exposure dosemeters. These recorded the dose staff were exposed to in the day to day duties; the dosemeters were sent every two months for analysis to the provider’s radiation protection adviser and medical physics expert organisation for checking and reporting. A dosemeter was also held to monitor exposure to parents and carers supporting their child or relative; a paper record log was held in the department of the dose each person received.

Access to the MRI unit was controlled by a secure door entry system. All staff, patients, carers and visitors entering the MRI unit were required to complete an MRI safety checklist, which included a range of checks for implants, metal and jewellery before they were admitted to the unit. This was required due to the potential for injury due to the strong magnetic field.

A protocol was in place for the management of any patients experiencing a medical emergency on the MRI unit; this ensured that crash-team staff not usually working on the unit did not enter the MRI scanning rooms. Staff were able to describe the process undertaken to remove a patient from the MRI scanner and move them to a recovery room where the emergency team could commence life support. Scenario training had been undertaken to ensure all members of the emergency team were aware of the process.

However, staff told us there was no policy or standard operating protocol in place for staff to follow if patients experience an MRI induced burn.

The interventional radiology unit used a modified version of the World Health Organisations (WHO) safer surgery checklist, which to decrease errors and adverse events during procedures. The use of the checklist was audited by the department.

The service had a policy for radiological investigations, blood tests and photographs in possible non-accidental injury (NAI). The policy included a flowchart to aid staff in the management and reporting of suspected non-accidental injuries. The policy detailed that the images should be reviewed by the local paediatric radiologist in line with Royal College of Radiologists standards before the child leaves the department, followed by referral of the images to a regional children’s hospital for expert radiological opinion.

Emergency resuscitation trolleys were located in each of the department’s units; these included equipment and emergency anaphylaxis drug boxes for both adults and children. All trolleys were secured with tamper tags and our review of the trolley/equipment checklists confirmed that regular checks of the defibrillator and single-use equipment was undertaken.

Line of sight was maintained for patients and carers in most of the waiting areas of the department, which meant staff could quickly identify and respond if someone became suddenly ill. However, the MRI waiting area was in a separate part of the department, which did not enable line of sight observation. Although MRI staff would regularly access the area to call the next patient, there remained a small risk that a deteriorating person in the waiting area may not be identified quickly.

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

The radiologist staff matched the planned number. The diagnostic imaging service had 35.5 whole time equivalent (WTE) staff.

The service’s turnover rates for radiologist staff were at the trust's target rate of 10% in the period between June 2018 and May 2019. However, for the same period the vacancy rate was 20%. The services leaders were aware of the impact of the national shortage of radiologists in recruiting staff, and were looking at incentive packages to attract radiologist staff to the trust, including retention bonuses and investment in IT equipment to enable radiologists to report on scan images from home.

Sickness rates for radiologist staff were low.

Managers could access bank and locum staff when they needed additional radiologist staff. However, the service had low rates of bank (2 per cent) and locum (less than one per cent) staff usage. Managers made sure locums had a full induction to the service before they started work.

**Trust level**

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2018 to May 2019</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average</td>
<td>Annual vacancy rate</td>
</tr>
<tr>
<td>Target</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>All staff</td>
<td>241.4</td>
<td>8%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>35.5</td>
<td>20%</td>
</tr>
</tbody>
</table>

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

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

**Bank staff usage**
Monthly bank hours over the last 12 months for medical staff shows an upward trend from January 2019 to May 2019. The radiology services manager was aware of this trend which was due to a recent staffing gap in the diagnostic imaging service provided within the women and children’s directorate, where a locum sonographer was used.

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

**Allied health professional staffing**

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

The radiology services manager and team leaders accurately calculated and reviewed the number of allied health professionals and clinical support workers needed for each shift in accordance with national guidance. However, we were told by staff that there were no band seven staff on night shifts, which were covered by less experienced staff.

The radiology service manager adjusted staffing levels daily according to the needs of patients. Staff were actively involved in the design of the staff rota. The number of nurses and healthcare assistants matched the planned numbers.

The diagnostic imaging service had low vacancy rates for allied health professional staff.

The service had low turnover rates for allied health professional staff, which were within the trust’s target.

The diagnostic imaging service had low sickness rates for allied health professional staff, which were within the trust’s target.

The service reported no usage of bank or agency allied health professional staff.

**Trust level**

The table below shows a summary of the allied health professional staffing metrics in diagnostic imaging at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Diagnostic imaging annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>June 2018 to May 2019</td>
</tr>
<tr>
<td></td>
<td><strong>Annual average establishment</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Bank hours - medical staff

![Graph showing monthly bank hours over the last 12 months for medical staff with a trend from January 2019 to May 2019.](image)
Allied health professional staffing rates within diagnostic imaging were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness, bank use and agency use.

**Vacancy rates**

![Vacancy rate - allied health professionals graph](image)

Monthly vacancy rates over the last 12 months for allied health professionals shows a downward trend from June 2018 to October 2018. However, the trend of improvement did not continue from October 2018 onwards and the latest two months showed a vacancy rate of 10%.

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

**Records**

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

Patient records were sufficiently detailed for their purpose and all staff could access them easily. The diagnostic imaging service predominantly used electronic patient records and scan images on trust systems that were secured by use of passwords. We reviewed four patient records; these were of good quality.

Safety checklists, including pregnancy check forms, were paper based; this enabled patients to sign to confirm the information they had provided. However, limitations of the diagnostic imaging electronic systems meant that these forms could not be scanned onto the electronic records. The service therefore held copies of these forms in files in the relevant control rooms, which were inaccessible to patients. This was a recognised risk of the system’s capabilities; however, it was hoped that an updated system, which was due to be implemented in early 2020 would mitigate the risk.

Staff told us of concerns about accessing scan images on the trust's picture archiving and communication system. Instability of the system meant that users could experience delays in accessing images, particularly if they had to restart their system.
Although we were unable to find any evidence of impact on reporting time performance, the instability of the system was a source of frustration particularly for reporting radiologists and reporting radiographers.

Leaders were aware of the issue and it was recorded on the risk register. The service anticipated the introduction of a new, updated, picture archiving and communication system in the early months of 2020 which was expected to resolve the problems staff experienced.

**Medicines**

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

The service held a small range of medicines, including contrast media and a very limited number of controlled medicines.

Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription.

We reviewed the patient group directions held by the diagnostic imaging service; these were for contrast media. The documents were developed, issued and authorised by the trust for each medicine that could be used. These were in date with the next review date clearly recorded, appropriately authorised, and signed by all staff who were able to administer the relevant medicines.

Contrast media was administered on the CT unit using injector pumps. Warming cabinets were available within the unit to warm contrast medicines prior to administration, which ensures better perfusion of the media throughout the body, enables clearer images, and causes less discomfort for the patient.

Staff stored and managed medicines in line with the provider’s policy. Medicines were securely stored in locked cabinets. Keys to the medicines cabinet and the controlled drugs cabinet were kept in a digitally coded locked key cabinet. As medicines can be affected by extremes in temperature, staff recorded the maximum and minimum ambient room temperatures. Staff were aware of the process to follow to check with pharmacy if the ambient room temperatures exceeded the expected range.

We reviewed a random sample of medicines held; all were within their respective manufacturer’s recommended expiry dates.

We reviewed a random sample of controlled drugs held; again, these were within their manufacturer’s recommended expiry dates. The controlled drugs log was completed appropriately and we saw confirmation that the log had been reviewed by the trust’s pharmacy team.

Staff followed current national practice to check patients had the correct medicines. We observed staff undertaken three-point positive patient identification checks prior to commencement of scans.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
Staff raised concerns and reported incidents and near misses in line with trust policy. This was evidenced in the trust’s incident log which we reviewed; however, one staff member told us they felt the department was not always good at reporting incidents.

Staff reported serious incidents clearly and in line with trust policy.

The service had no never events.

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

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

There was evidence that changes had been made as a result of feedback. (Provide information about improvements in safety specific to this service)

Between November 2018 and October 2019, staff in the diagnostic imaging service reported 284 incidents trust-wide. The majority of these incidents were classed as near misses or caused no harm to the patient. A further 66 incidents were closed as low harm to the patient; three were classed as moderate harm; and, one incident was recorded as contributing to a patient’s death.

Staff received feedback from investigation of incidents, both internal and external to the service. Leaders told us feedback and learning from incidents was shared with staff in safety huddles and in team meetings.

**Never Events**

A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

From July 2018 to June 2019, the trust did not report any never events for diagnostic imaging.

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

**Breakdown of serious incidents reported to STEIS**

**Trust level**

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

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic incident inc. delay (inc. failure to act on test results)</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

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

We reviewed the root cause analysis investigation reports for these serious incidents. The reports included a chronology of the events leading up to and contributing to each incident, consideration and discussion of the findings of the investigation by the serious incident panel, identification of the root cause, contributory factors, conclusion, lessons learned, recommendations for improvement, and
an action plan. Each report provided clear evidence of the application and implementation of the duty of candour.

In the period between July 2018 and the inspection, the diagnostic imaging service reported one incident to CQC in line with the Ionising Radiation (Medical Exposure) Regulations 2018. The incident occurred in October 2019 and related to an unnecessary radiation exposure following a referred using an incorrect request form. The investigation of this incident was ongoing at the time of the inspection.

Is the service effective?

Evidence-based care and treatment

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

Staff followed the trust’s policies to plan and deliver high quality care according to best practice and national guidance.

The service’s policies and protocols were available on the trust’s intranet system which staff could access. We reviewed 12 policies, procedures and works instructions for the diagnostic imaging service. All documents bar one were up to date and had been appropriately reviewed. However, the works instructions we reviewed did not, generally, refer to professional guidance, while the policy documents inconsistently included links to guidelines from a range of organisations such as the National Institute of Health and Care Excellence (NICE), the Royal College of Radiologists, the College of Radiographers, and the British Society of Sonographers.

All modalities worked to the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). The IR(ME) regulations set out the requirement for the practitioner and operator to “ensure that doses arising from the exposure are kept as low as reasonably practicable consistent with the intended purpose”.

National diagnostic reference levels are the mean radiation dose levels for groups of standard-sized patients. It is expected that these reference levels should not be exceeded for standard procedures when good and normal diagnostic imaging practice is applied. There are usually higher than local diagnostic reference levels which are the expected mean radiation dose received for standard-sized patients on the specific equipment used.

Diagnostic reference levels were used by staff as a guide to understand if equipment was not operating correctly, when the technique used by the operator was poor, or when a patient may have received a larger than expected dose.

The radiographers working in X-ray had a good working knowledge of the doses.

Staff in the MRI unit told us there was no policy or procedure in place for the management of MRI induced burns; this was despite a recent incident where this had occurred. A staff member told us there were no checklists in place for the administration of contrast media in CT procedures; the only document available at the time of the inspection, for CT colonography procedures, was still in draft form. We observed at least one patient interaction where staff did not ask the patient about allergies prior to the administration of contrast.
Nutrition and hydration

Due to the nature of the diagnostic imaging services provided, meals and drinks were not routinely provided for patients. However, the diagnostic imagine services department was located in the main hospital building close to a range of shops and cafes where patients and carers could purchase a range of food and drink items.

Patients were given advice on their appointment letter about any specific preparation required for scans. For example, the need to drink sufficient amounts of water for certain types of abdominal ultrasound scan. We saw that water dispensers were available within the department.

Pain relief

Staff monitored patients to see if they were in discomfort or pain. Due to the nature of the services provided, formal pain assessment was not undertaken and pain relief was not routinely used within the diagnostic imaging department for the majority of diagnostic procedures. Topical anaesthetic cream was available, if needed, to ease any patient discomfort in inserting contrast media injections.

However, pain relief and sedation medicines were held within the department to be used as prescribed for invasive procedures such as those carried out by the interventional radiologists.

We observed staff checking that patients were comfortable when positioning them before and during their scans.

Patient outcomes

Staff monitored the effectiveness of care and treatment. Managers and staff used the results to improve patients’ outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

The nature of the diagnostic imaging services provided meant there was limited opportunities available to monitor patient outcome.

Quarterly, unminuted, education meetings were held to discuss any queried images or reports. Any systemic patterns identified were fed to the radiology service leads for remedial action to be taken. Individual discrepancy feedback was provided to the staff member involved, and subsequent reflection exercises were included in the staff member’s appraisal.

The diagnostic imaging service participated in the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017) clinical audit for 2019. The audit showed mixed results in comparison with the previous audit in 2018; some audit criteria showed increased compliance, while other criteria indicated decreased compliance. We saw evidence of the service’s completed action plan for the areas identified in the audit.

An audit of the use of the modified World Health Organisation safer surgery checklist was undertaken in May and June 2019. The results of the audit indicated that the checklist was only completed correctly in 30.4% of the patients sampled, with the sign-out section presenting the largest proportion of errors. An action plan to redesign the form to reduce the complexity of the
questions asked, and to develop an electronic version for inclusion in patients notes, was ongoing at the time of the inspection.

The service participated in a range of other audits during 2019. These included:

- An audit of asymmetrical breast density in prevalent recall, which demonstrated that analysis and understanding of benign types of asymmetrical density can directly reflect a decrease in the recall rate.
- An audit of Cardiac CT dose, which identified the hospital’s advance new CT scanner had significantly reduced the patient radiation dose.
- An audit to evaluate the use of further compression views in the NHS breast screening programme assessment clinics. Compression views are images taken of the breast when it is compressed. The outcome of the audit indicated that, in certain circumstances, further compression views were not required; this could result in reducing the radiation dose and discomfort to patients, increase scanning capacity and speed-up assessment clinics.
- An audit on the inclusion of the anal canal on small bowel protocol MRI, which indicated the importance of following the departmental guidelines for certain types of images, and for encouraging reporting radiologists to comment on the inclusion of the anal canal in the image and/or the presence of any peri-anal sepsis.

At the time of the inspection, the diagnostic imaging service did not participate in the Imaging Services Accreditation Scheme (ISAS). ISAS is a patient-focused assessment and accreditation programme that is designed to help diagnostic imaging services ensure patients consistently receive high quality services, delivered by competent staff working in safe environments.

**Competent staff**

**The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers made sure staff received any specialist training for their role.

Managers supported staff to develop through yearly, constructive appraisals of their work, and staff had the opportunity to discuss training needs with their line manager as part of the appraisal. However, we could not be sure radiographer staff were always supported to develop additional skills and knowledge. The service had focused on developing radioographer reporting skills for plain-film x-ray but had not been able to support additional reporting skills for some types of common CT scans.

Managers gave all new staff a full induction tailored to their role before they started work. New staff worked supernumerary to the staffing numbers. The length of this period depended on the individual’s experience; newly qualified staff were offered a three month period while this was reduced for experienced staff relocating into the service.

Within ultrasound new staff were supervised in the scanning of up to five patients for each type of scan with training lasting between three and six months depending on experience. With CT, new staff worked in pairs to completed an induction checklist under the support of a liaison radiologist.

However, we were not able to find any evidence of a quality sampling process in place for the quality of images or reporting for established staff. This meant that potential quality issues were only picked up if the image or report was queried by the referrer.
Six radiographers had achieved post-graduate certification in radiology; these staff vetted referrals into the diagnostic imaging service for their appropriateness.

The diagnostic imaging service had a practice based educator who supported the learning and development needs of staff.

Managers identified poor staff performance promptly and supported staff to improve.

**Trust level**

From April 2018 to March 2019, 84.1% of staff within diagnostic imaging at the trust received an appraisal compared to a trust target of 88%.

A breakdown of appraisal completion rates by staff group is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>18</td>
<td>20</td>
<td>90.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>43</td>
<td>48</td>
<td>89.6%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>102</td>
<td>120</td>
<td>85.0%</td>
<td>88.0%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>22</td>
<td>32</td>
<td>68.8%</td>
<td>88.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Between April 2018 and March 2019 radiologist staff within the service had met the trust’s target for completion of appraisals at 90%. For the same period, allied health professional staff had marginally missed the trust’s target at 85%.

At the time of inspection, mandatory training completion rates for allied health professional staff at Arrowe Park only is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>19</td>
<td>21</td>
<td>90.5%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>63</td>
<td>93</td>
<td>67.7%</td>
<td>88.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

*(Source: Post-inspection additional data request DR137)*

At the time of the inspection radiologist staff within the service had met the trust’s target for completion of appraisals. Allied health professional staff had not yet, mid-way through the reporting period, achieved the trust's target with 67% having received an appraisal.

**Multidisciplinary working**

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

We observed good working relationships within the diagnostic imaging service between radiologist, radiographer, care support workers and administration teams. Radiographer staff were rotated between the CT and MRI modalities to enhance their skills.

The interventional radiologists attended relevant multidisciplinary meetings throughout the hospital; for example, the lung cancer meeting.
Seven-day services

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

The diagnostic imaging service provided outpatient magnetic resonance imaging (MRI) scanning appointments seven days a week between 7.30am and 7pm Monday to Friday, 7.30am to 7.30pm on a Saturday, and 8am to 7pm on a Sunday.

Outpatient computerised tomography (CT) scans were offered seven days a week between 8.30am and 6.45pm Monday to Friday, and between 8.30am and 3.45pm at the weekend.

Outpatient ultrasound appointments were offered seven days a week between 8.30am and 6pm Monday to Friday, and 9am to 5pm at the weekend.

Outpatient plain film X-ray GP referrals were accommodated on a walk-in basis between 8.30am and 4.45pm Monday to Friday. The service was able to provide appointments outside of these hours at patient request.

Health promotion

Due to the nature of diagnostic imaging services there was limited scope for staff to promote health. However, staff provided safety netting advice (to attend the emergency department if they experienced any bad reactions) to patients after scans, particularly when contrast media had been used.

Patient information leaflets on the extravasation of contrast media (contrast media leaking into tissues surrounding the vein) were available and provided to patients suspected or known to have suffered an extravasation episode.

Warning signs were displayed within the department to remind patients to inform staff if they were, or suspected they were, pregnant.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, formal written consent forms for different types of procedures were not always in place.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. For X-ray and walk-in services, consent was primarily obtained on an implied basis. However, at the time of the inspection, staff told us they had only one formal patient consent form for CT; this was for CT colongraphy examination and was in draft form awaiting sign-off.

For interventional radiology, written consent was obtained from the patient for the procedure and for any anaesthetic to be used. This was undertaken with the patient by the radiologists.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. This information was captured on consent form four. Staff told us that, for inpatients, consent was usually obtained on the inpatient ward prior to transfer to the diagnostic imaging department.
Staff told us the service treated young adults ages 16 and over as adults, and that parental consent was obtained for all children and young people under the age of 16. Staff we asked did not have an understanding of Gillick Competence Guidelines.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Prior to inspection, we routinely ask for training completion data relating to mental capacity act and deprivation of liberty training for staff. The trust did not supply us with this information.

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

We asked the radiology services manager about this during our visit. They told us that mental capacity training within the trust was role specific; there was no specific course for radiology staff. However, mental capacity awareness training was included in the trust’s protecting vulnerable people mandatory training course, which had been completed by 88.2% of allied health professional staff and 95% of radiologist staff.

Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We observed staff interacting with patients throughout the diagnostic imaging services. Interactions were kind and compassionate.

We spoke with ten patients and carers during the inspection. Patients we talked with, before and after their scans, said staff treated them well and with kindness. The service encouraged patients to complete the NHS Friends and Family Test feedback. Although the divisional data could not be disaggregated from the outpatients data, between April 2019 and September 2019 and average of 94.3% of patients who responded would recommend the services provided by the division with an average of only 2.5% of those who responded that would not recommend the services.

Staff followed policy to keep patient care and treatment confidential. The waiting areas in the department were located near to the reception desks; however, we observed that receptionist staff maintained privacy as much as possible during the booking in process.

Emotional support

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

Staff understood the emotional and impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We observed staff communicating with patients during their scans to check they were comfortable and were not experiencing any distress.

Staff were able to play ambient music in the CT and MRI scanner facilities to reduce patient anxiety or distress. The department’s new MRI scanner was equipped with a screen for displaying films and cartoons; this helped to distract children and keep them calm during their scan. The department held
stocks of CDs and DVDs; however, patients could, if they wished, bring their own favourite music or show with them.

The service supported parents and carers to accompanying their child in the scan rooms with appropriate safety checks, precautions and dosemeters put in place.

At the time of the inspection, the service recognised that it did not have sufficient numbers of clinical support workers to meet the demand for chaperones. This was on the departments risk register.

**Understanding and involvement of patients and those close to them**

Staff supported and involved patients, families and carers to understand the reasons for their scan and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, and explained what to expect during their scans.

Patients gave positive feedback about the service. We saw evidence of a number of compliments and thank you cards received by the diagnostic imaging service.

All patients we spoke with had received information with their appointment letter on how to prepare for their scan/procedure, if any was required. We also observed staff telling patients what to expect after their scan, including when their results would be available to their referrer.

Two patients we spoke with were returning to the service for follow-up procedures following previous diagnostic scans. The patients told us they had been kept informed of what would happen and why the follow-up procedure was required.

The CT lead radiographer had designed a slide presentation that was displayed on the televisions within the waiting areas of the department. The presentation provided a range of information to patients in relation to their scans, what the scans involved and additional useful information. This had been developed following analysis of questions that were frequently asked by patients before, during and after their appointments.

**Is the service responsive?**

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

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

The diagnostic imaging department was clearly signposted and was located close to the hospital’s main entrance, and a short distance from the hospital’s pay as you leave carpark. The hospital also hosted a free carpark on site, although this was located further away to the side of the main hospital building. The department was also close to a hospital café, where patients could obtain refreshments. Toilets were available near the waiting areas in the department.

Managers planned and organised services so they met the changing needs of the local population. Outpatient diagnostic imaging CT/MRI and ultrasound services were available seven days a week during the daytime. CT scans were available out of hours. Inpatient scanning services were available during the daytime and out of hours for urgent scans in line with the service’s set criteria.
The service relieved pressure on other departments when they could treat patients in a day. A walk-in service was available for patients referred by their GP for plain film X-ray; this reduced the need for patients to make appointments. Urgent referrals for scans were accepted from internal, as well as external, referrers. The service had six radiographers managing the portable X-ray machines for undertaking inpatient X-rays on wards.

The ultrasound service had developed a ‘one-stop neck clinic’, delivered on a Wednesday and Thursday morning for patients with suspected cancer.

Facilities and premises were generally appropriate for the services being delivered. However, the legacy design of the building created a number of space challenges; for example, the CT/ultrasound patient changing area was limited and could be observed directly from the main hospital corridor.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff were able to accommodate longer appointment slots for patient who required additional support if this information was made available by the referrer.

Managers monitored and took action to minimise missed appointments. Patient ‘did not attend’ rates were low; this had improved following the introduction of a mobile phone text reminder service. Managers ensured that patients who did not attend appointments were contacted.

**Meeting people’s individual needs**

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

The diagnostic imaging service was based on the ground floor of the hospital building and was accessible for patients living with mobility challenges. The X-ray department was located next to the emergency department with just a short walk across a corridor which meant children's privacy and dignity were maintained. The CT/MRI and ultrasound department was located further along the ground floor corridor.

The general patient waiting areas in the diagnostic imaging service’s department, were appropriate for the purpose. However, we noted that the patient changing area for the CT department, which was also used for inpatients on trolleys to wait, provided very limited privacy.

The changing area, which only had a paper curtain to draw when a patient was getting changed, was opposite double doors onto the main hospital corridor. At the time of the inspection, the double-doors were kept open. Patients waiting in that area could be easily observed by passers-by in the corridor. Staff also told us that some patients for CT were left along in the scanning room, which is a controlled area, to change.

The nature of the services provided meant that patients did not stay within the department for lengthy periods of time. However, staff told us they could support extended appointment times for patients living with mental health issues, learning disabilities or dementia if this information was shared in advance by the referrer. This included scheduling patients towards the end of the morning or end of day shifts to give them more time and to feel less rushed.

The diagnostic imaging service had a range of information leaflets for different types of scan for all modalities available for download on the trust’s website. Information leaflets were also available within the department. Leaflets were in English. We discussed this with the radiology services manager who told us the predominant patient demographic within the local area was British Caucasian.
Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed, if they were aware of the need in advance.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Patients were referred electronically to diagnostic imaging services by their GPs, hospital consultants and other practitioners who had referring rights.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Patients could call and change the appointment if required. The service monitored ‘did not attend’ rates with a target of less than 5% of patients not attending their appointment. Between November 2018 and October 2019, average did not attend rates were as follows: X-ray - 0.1%; ultrasound – 10%; CT – 3.9%; MRI – 3.6%; and, dexta – 0%. The service had plans to undertake a capacity/demand review for ultrasound to understand how it could reduce the number of patients who did not attend their appointment. Data relating to the number of cancellations by the provider was not available to us.

The monthly diagnostics waiting times and activity diagnostics collection (DM01) is the primary source for diagnostics waiting times and activity for 15 key diagnostics tests. It is used to measure performance against the operational standard, that less than one percent of patients should wait six weeks or more for a diagnostics test. Performance was monitored once a week in a performance meeting for each modality.

Patients with the most urgent needs had their care prioritised. The trust had set a target for 99% of patients with urgent referrals to be seen within two weeks for most of the diagnostic imaging modalities, and 100% to be seen on the same day for ultrasound scans.

However, interventional radiology staff expressed frustration at recovery bed availability in the hospital for patients that had received general anaesthetic during their procedures. Staff told us that lack of a recovery bed was the main cause for procedure cancellation, and was on the department’s risk register. A process was in place with the bed management team to mitigate the potential impact of the risk, and the hospital was further looking into the possibility of ring-fencing a bed for recovery of these types of patients.

Diagnostic waiting times (percent waiting 6+ weeks)

Between 01 June 2018 and 31 May 2019 the percentage of patients waiting more than six weeks to see a clinician was lower (better) than the England average, and was on the decreasing trend. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England. The chart below shows 6+ weeks percentages over time.
The trust reported performance against a range of targets for the different diagnostic imaging modalities as shown in the tables below for the period between November 2018 and October 2019.

On average, the service achieved its targets for both routine and urgent X-ray imaging appointments:

<table>
<thead>
<tr>
<th>Modality</th>
<th>Average performance November 2018 to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Routine appt (within 1 week)</td>
</tr>
<tr>
<td>X-ray</td>
<td>99.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England – Diagnostic Waits)

On average, the service achieved its target for routine appointments; however, it narrowly missed its targets for urgent appointments and same day appointments:

<table>
<thead>
<tr>
<th>Modality</th>
<th>Average performance November 2018 to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Routine-6 weeks</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>99.8%</td>
</tr>
</tbody>
</table>

(Source: Post-inspection additional data request DR124)

On average, the service achieved its target for routine appointments for MRI, and Dexa scans, and its urgent appointment for CT scans. The service narrowly missed its target for routing CT appointments, and had a lower achievement for urgent MRI scans; however, it had recently installed a new MRI scanner which meant that capacity had been temporarily reduced during installation.

<table>
<thead>
<tr>
<th>Modality</th>
<th>Average performance November 2018 to October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Routing appt (within 6 weeks of referral)</td>
</tr>
<tr>
<td>CT</td>
<td>98.4%</td>
</tr>
<tr>
<td>MRI</td>
<td>99.5%</td>
</tr>
<tr>
<td>Dexa</td>
<td>99.8%</td>
</tr>
</tbody>
</table>
Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Leaflets about how to complain were available at the department’s reception desks. Information on how to complain was also available on the trust’s website.

Staff understood the policy on complaints and knew how to handle them. Staff we asked were aware of the general principles of the duty of candour; to be open and honest.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. The radiology service manager told us it was rare for the service to receive a complaint directly about the diagnostic imaging department, which likely accounted for the low numbers reported. The manager went on to explain that any dissatisfaction with the service generally formed part of a much wider complaint about other services within the hospital. In these circumstances, the department contributed to the overall complaint response, but the complaint would be logged against the main service complained about.

Summary of complaints

Trust level

From July 2018 to June 2019 the trust received two complaints in relation to diagnostic imaging (0.9% of total complaints received by the trust). The trust took an average of 36.0 days to investigate and close complaints, this not in line with their complaints policy, which states complaints should be dealt with within 30 working days.

However, the trust target for completing complaints prior to December 2018 had been 25, 45 or 60 working days (depending upon complexity). A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrowe Park Hospital</td>
<td>Treatment and Procedure</td>
<td>1</td>
<td>50%</td>
</tr>
<tr>
<td>St.Catherine`s Hospital</td>
<td>Tests and results</td>
<td>1</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Trust level</strong></td>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

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

We reviewed the complaint relating to Arrowe Park, which was complex and as such met the trust’s 60 working day target.

Number of compliments made to the trust

From July 2018 to June 2019 there were 15 compliments received for diagnostic imaging at the trust. A breakdown of compliments by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clatterbridge General Hospital</td>
<td>6</td>
<td>40.0%</td>
</tr>
<tr>
<td>Arrowe Park Hospital</td>
<td>5</td>
<td>33.3%</td>
</tr>
<tr>
<td>St Catherine’s Hospital</td>
<td>4</td>
<td>26.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
We viewed a range of compliment cards and emails from patients recorded by the provider for diagnostic imaging services at Arrowe Park.

Is the service well-led?

Leadership

The divisional leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The diagnostic imaging services were delivered within the trust’s division of clinical support and diagnostics. The division was led by a triumvirate of a divisional director, associate medical director, and a divisional director of nursing.

The diagnostic imaging services were led at department level by the radiology services manager, who reported to the divisional director. The previous radiology services manager had recently left the post and the current manager had been appointed to the interim post six weeks prior to the inspection having previously undertaken the operational and performance manager for two and a half years.

The radiology services manager was, in turn, supported by a deputy clinical services manager, an interim operational and performance manager, an ultrasound and computerised tomography (CT) manager, and an MRI manager.

They divisional leaders supported the interim managerial staff to develop their skills in these more senior roles. At the time of the inspection, the interim managers were still embedding in their roles. However, we received inconsistent messages from operational staff on support of development to take on new skills.

The divisional and departmental managers were able to clearly describe the department’s risks, and the priorities, and challenges, for addressing and remedying these. For example, the age of the equipment within the department; recruitment challenges reflected by national shortages of qualified radiologists and sonographers; and, increasing demand on services.

Operational staff in the department were aware of the managerial and escalation structures within the department. Departmental and divisional leaders were visible within the department.

Vision and strategy

The service had a vision for what it wanted to achieve and were developing a workforce plan in consultation with staff. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The diagnostic imaging service were aligning with the radiology services in the Cheshire and Merseyside clinical network. The service’s leaders were conscious of the challenges this brought in ensuring radiology and imaging systems were aligned to provide seamless patient care in the area, and in meeting the capacity demands within the region. It was one of the key factors in decisions surrounding the replacement of equipment within the department to ensure that any new equipment was sustainable in the plans for development of the service, and for diagnostic imaging services in the region.
The diagnostic imaging service’s leaders were developing a workforce plan to manage future capacity and demand for the service, and to attract new radiologist staff to the trust. This included investment in equipment and IT infrastructure to enable radiologists to view images and report on them from home; and a retention bonus for new staff to encourage them to stay with the trust.

In addition, the service leaders were keen to develop radiographer staff; for example, to place peripherally inserted central catheter (PICC) lines or sciatic drains in patients. The current focus, prior to the inspection, was to develop radiographer staff in the reporting of plain film X-ray images.

However, education budget caps remained a challenge, particularly in aligning staff development to business needs. The leaders acknowledged this was exemplified in concerns expressed by some radiography staff that upskill training in reporting of certain types of common scans had not been supported. It was recognised that increasing reporting capability of radiographers would assist in managing demand; however, this would rely on the support of supervising radiologists and impact on radiologist resource.

**Culture**

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

We spoke with a range of staff during the inspection, including managerial, radiologist, radiographer, support work, and reception staff. The majority of staff we spoke with were proud of the diagnostic imaging service, and spoke highly of their leaders and felt supported by them. Although this was not a universal view, limited opportunities for development appeared to be the main source of dissatisfaction, rather than the culture of the department.

Staff felt able to speak with their line or senior managers about any concerns and to request a temporary stop to procedures without any fear of repercussions if they had any safety concerns.

Staff we asked were aware of the principles of the the regulatory duty of candour in line with the joint Nursing and Midwifery Council and General Medical Council guidance, Openness and honesty when things go wrong: the professional duty of candour. Staff were able to describe situations were the duty of candour had been applied. Our review of root cause analysis investigation reports also confirmed that the duty of candour had been complied with.

The duty of candour requires a health service body, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, to notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

**Governance**

Leaders did not consistently operate effective governance processes throughout the service. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Gaps in governance oversight were evidenced in a number of areas. These included gaps in the process for quality assurance of diagnostic images which increased the risk of harm to patients through potential misdiagnoses or delayed diagnoses; the inconsistent referencing of the evidence-
base relied on for some of the service’s policies and procedures; the inconsistent display of up to
date diagnostic reference levels.

Although, in line with the standards of the Royal Colleage of Radiology, the service held unminuted
quarterly radiology educational case meetings (discrepancy meetings) to discuss reports queried by
referers, it did not have a formalised approach for routine quality sampling, or second-checking, of
images or reports undertaken by its staff. This meant the service relied soley on other professionals,
such as the referring clinicians, to identify and raise any concerns with the report or the image to the
service. The lack of a routine quality sampling process meant there was a lost opportunity to identify
potential errors with images, reports or staff practice at an early stage. This increased the risk of
potential misdiagnoses or delayed diagnoses for patients.

The overall governance structure within the diagnostic imaging service was led by a consultant
radiologist, and governance oversight was provided through the division’s monthly clinical
governance meeting. The meeting was also attended by the divisional governance lead, the
operational and performance manager, the radiology quality lead, the lead radiation protection
supervisor, and the leads for each diagnostic imaging modality.

The governance meetings had a standard agenda and provided oversight of the departments risks,
and risk register; incidents, including serious incident investigations; complaints and compliments;
external reviews; clinical audits; review of any new national or professional guidance; review and
sign-off of updated leaflets, policies and procedures, infection control; safety alerts; pharmacy
updates; and updates on any research projects.

Radiation protection advice and medical physics expert advice was provided under contract by an
external organisation, which was recognised by the Health and Safety Executive as a Radiation
Protection Adviser Body under Regulation 13 of The Ionising Radiation Regulations.

The radiation safety committee met twice a year. The last meeting in May 2019 was attended by the
radiology services manager; the associate medical director; the operation and performance
manager; the principal community radiographer; the external lead radiation protection advisor and
principle scientific officer (medical physics expert); and the orthopaedic theatre co-ordinator.

The safety committee meetings had a standard agenda and provided oversight of the radiation
protection advisor and medical physics expert reports; reportable IR(ME)R incidents and near
misses; referral criteria and protocols; review of radiation safety policies in line with IR(ME)R and
IRR regulations; and review of equipment against the requirements of the regulations.

Senior staff in the diagnostic imaging service met fortnightly. As will the other governance meetings,
the senior staff reviewed any performance or quality issues arising in the service.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and
escalated relevant risks and issues and identified actions to reduce their impact. They had
plans to cope with unexpected events.

The divisional leads and the radiology services manager could describe the main risks to the critical
care service. These included, although were not limited to, risks associated with the age of the
service’s equipment, challenges with the stability of the imaging archiving system, challenges in the
recruitment of staff against the background of national shortages, and the availability of chaperones.

The leaders described the actions being taken to mitigate and address these risks, although some of
the issues required significant amounts of capital expenditure by the trust. This included the
replacement of the image archiving system, which was expected in the early part of the 2020. It was hoped that replacement of the system would bring the service into line with other partners in the area and support more efficient transmission of images to other hospitals, or professionals, as required.

The described risks were reflected in the service’s risk register which, at the time of the inspection, included six open risks. Each risk had a named owner and had been scored for severity and likelihood. This led to one risk being rated ‘red’ with a risk score of 15, three rated as ‘amber’ with a risk score of 12, and two rated as ‘yellow’ with a risk score of 9. The register included the controls that were in place, and actions to be taken to mitigate the risk, with a date for next review clearly indicated. The controls and mitigations matched the descriptions given to us by the service’s leaders.

The diagnostic imaging service actively participated in a range of audits, including the IR(ME)R compliance audit. The audit findings had been escalated to the risk register, and meetings had been convened with the aim of improving areas of compliance weakness in the audit. We saw evidence of the completed action plan.

The service had a standard operating Process for Audit against IR(ME)R 2017 Employers Procedures. This included an audit calendar for each year to ensure each modality had been assessed, and policies and procedures were reviewed to check for compliance with the regulations.

The service also participated in a range of clinical audits to improve performance; these included, although not limited to, audit of the amended WHO safer surgery checklist; evaluation of staging investigations for breast cancer patients; appropriateness of use of CT pulmonary angiography investigation of suspected pulmonary embolism (blood clots on the lung); and, inclusion of the anal canal in small bowel MRI images. Processes were in place for reviewing and escalating audit findings as appropriate.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The service collected information on the performance of all its diagnostic imaging modalities and reported these on a monthly basis to the local clinical commissioning group. Performance criteria monitored included referral to examination and reporting times for routine and urgent requests and the number of patients who did not attend their appointments.

Staff had access to up-to-date, accurate information on patients’ care and treatment. Patient records were predominantly electronic although, particularly, radiologist and reporting radiographer staff told us they were frustrated at the challenges presented by the instability of the service’s image archiving system. This could cause delays in reporting on the images and was recorded as a risk on the service’s risk register. Plans were in place for replacing the equipment.

The service’s policies, standard operating procedures, and works instructions were available on the trust’s intranet. We reviewed a range of policy and procedure documents held and these were the latest versions; all had a clear review date in place. Staff knew how to access the latest information.

**Engagement**
Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The diagnostic imaging service participated in the NHS Friends and Family Test feedback system. The data was collated at divisional level trust-wide and, as such, could not be disaggregated from the outpatients friends and family data. However, between April 2019 and September 2019 and average of 94.3% of patients who responded would recommend the services provided by the division with an average of only 2.5% of those who responded that would not recommend the services.

Staff safety huddles were held at the start of each shift. These were used to pass on any relevant safety information, information about incidents or complaints. However, staff told us that formal staff members were held irregularly within the department; usually on the trust’s audit days. Staff also used an encrypted group messaging service to share relevant information about the service.

The diagnostic imaging service was aligning with the Cheshire and Merseyside clinical network to share best practice, challenges, and to enable systems and processes to be aligned as appropriate.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. However, some staff expressed frustration at a perceived reluctance to develop radiographer staff in the reporting of some common types of images.

Conversations we had with managers and staff, on the whole, indicated there was a willingness to learn and continuously improve within the diagnostic imaging service; this was evident in some of the audits undertaken within the different modalities.

The service leaders understood the challenges faced by the department, particularly around recruitment and radiology reporting capacity. However, some staff also expressed frustration at a perceived reluctance to develop radiographer staff in the reporting of some common types of images.
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.

Medical care (including older people’s care)

**Facts and data about this service**

The medical care service at Wirral University Teaching Hospital NHS Foundation Trust provides care and treatment for geriatrics, diabetics, cardiology, gastroenterology, respiratory, endoscopy, dialysis, dermatology, rehabilitation, haematology and nephrology. There are 503 medical inpatient beds located across 20 wards/ units; Ward 25, 21, 22, 23, 24, 26, 27, 30, 32, 33, 36, 37, 38, MSSW, OPAU, AMU, CCU, Ward D1, M1 and CGH Rehab.

The trust provides acute services from two sites:

- Arrowe Park Hospital: 421 beds are located within 17 wards / units
- Clatterbridge Hospital: 82 beds are located within three wards

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

The trust had 50,464 medical admissions from March 2018 to February 2019. Emergency admissions accounted for 26,192 (51.9 %), 1,383 (2.7 %) were elective, and the remaining 22,889 (45.4%) were day case.
Admissions for the top three medical specialties were:

- General medicine: 11,865
- Gastroenterology: 10,216
- Geriatric medicine: 8,077

(Source: Hospital Episode Statistics)

The Clatterbridge Rehabilitation Centre CRC is a 30 bedded rehabilitation unit staffed 24 hours a day and has consultant pharmacy, social work, physiotherapy and occupational therapy input Monday to Friday. The age group accepted is from 18 years onwards both male and female.

M1 Medical Rehabilitation ward is a 40 bedded rehabilitation unit with 40 beds and takes both adult males and females.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Services at Clatterbridge hospital provided mandatory training in key skills to most staff.

The compliance rates for training modules was lower than the trust target and differed from one course to the other, however most courses compliance rates were close to the trust target.

Training was provided in a number of training modules which included, health and safety, infection prevention control and manual handling and medicines management.

We found that only two out of 10 courses hit the 95% target for compliance for nursing staff. The other eight modules reached averages of 80% to 90%.

The medicines management module was the only one that dipped below 80% for nursing staff, reaching a completion figure of 70%, with 21 out of 30 nursing staff completing the training.

The trust had reviewed some of its compliance rates and consequently identified gaps in some areas of training. One of the areas identified was resuscitation training and this was on the trusts risk register.

Services at Clatterbridge hospital had not met the compliance target set by the trust but they had significantly higher than other areas of medicine directorate.

Clatterbridge medical staffing compliance rates were lower than nursing staff and all nine training modules compliance rates were under the trust compliance target of 95%.

The least compliant modules for medical staff were manual handling and data security, where only four out of eight medical staff had completed this training.
Whilst this was the case, actual numbers of medical staff in Clatterbridge were low and therefore failure to do the training had a greater impact on outcomes.

Training on the two wards was conducted on induction and on a yearly or three yearly basis. Staff told us that training was accessible either online or face to face.

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

**Mandatory training completion rates**

**Clatterbridge Hospital**

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at Clatterbridge Hospital for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>15</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>29</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>28</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>28</td>
</tr>
<tr>
<td>Data Security Awareness Level 1</td>
<td>26</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>25</td>
</tr>
<tr>
<td>Fire Safety Level 2</td>
<td>25</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>25</td>
</tr>
<tr>
<td>CPR</td>
<td>24</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>21</td>
</tr>
</tbody>
</table>

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at Clatterbridge Hospital for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>6</td>
</tr>
<tr>
<td>Health &amp; Safety Level 1</td>
<td>6</td>
</tr>
<tr>
<td>Equality &amp; Diversity Level 1</td>
<td>5</td>
</tr>
<tr>
<td>CPR</td>
<td>5</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>5</td>
</tr>
<tr>
<td>Fire Safety Level 1</td>
<td>5</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>5</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>4</td>
</tr>
<tr>
<td>Data Security Awareness Level 1</td>
<td>4</td>
</tr>
</tbody>
</table>

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

**Safeguarding**
Staff understood how to protect children, young people and families 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 when and how to apply it.

The services used a trust wide overarching in-date safeguarding policy.

Staff we talked to on both wards knew that the policy existed, had access to it through the intranet and were aware of how it supported decision making.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding training at Clatterbridge hospital included both adult and children’s safeguarding modules.

Staff had a good compliance rate for safeguarding training across all the safeguarding training modules.

Staff demonstrated awareness of what to do if they had safeguarding concerns and could give examples of how to protect patients, visitors and families.

Staff we spoke with told us they knew how to make a safeguarding referral and who to inform if they had concerns.

Staff told us they could gain expert advice from a number of sources including the trust safeguarding team, who were accessible and based at Arrowe Park hospital. Support was also available from clinical and managerial leads in the service and links in the local authority.

Staff could also access an on-call manager in the trust after hours. Staff were able to describe how they pro-actively co-operated with partners in social care and from other professions to protect children and adults.

**Safeguarding training completion rates**

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

**Clatterbridge Hospital**

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at Clatterbridge Hospital for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</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>Protecting Vulnerable People Level 1</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 3</td>
<td>28</td>
<td>28</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Protecting Vulnerable People Level 2</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95.0%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In medicine, the 95% target was met for two of the three safeguarding training modules for which qualified nursing staff were eligible.

In two of these training modules only one staff member was eligible for the protecting vulnerable people level 1 and 2 training modules.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at Clatterbridge Hospital for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</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>
</tbody>
</table>

In medicine, the 95% target was met for two of the three safeguarding training modules for which qualified nursing staff were eligible.

In two of these training modules only one staff member was eligible for the protecting vulnerable people level 1 and 2 training modules.
In medicine, the 95% target was not met for the one safeguarding training modules for which medical staff were eligible. Whilst this was the case actual numbers of medical staff eligible were low and therefore failure to do the training had a greater impact on outcomes.

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

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The two wards used an overarching infection control policy which was provided by the trust for its staff to manage and minimise the risk to patients. The policy was in date and staff we spoke with knew about it and where to find it. The units were supported by a trust wide infection prevention and control team.

Staff on the medical wards received training in infection control measures with a trust target of 95%. Medical services at Clatterbridge hospital had a training compliance of 83%, for nursing staff.

The actual numbers of medical staff eligible at Clatterbridge was low in number and therefore failure to do the training had a greater impact on outcomes. Medical staffing compliance was lower at 63% with five out of eight medical staff competing the training

The two wards contributed to a trust wide infection prevention control audit. We were provided with the audit actions which the wards participated in and these were positive in outcome.

The medical wards at Clatterbridge conducted regular infection control audits. We were provided with information that showed that between July to September 2019, each ward achieved audit scores of over 95% in every month.

We were told that staff reported any infection on the wards centrally so that this could be collated by the trust. A serious incident panel reviewed any deaths or serious incidents relating to infections and the wards were linked into this process through their divisions.

The infection prevention and control team proactively promoted infection control measures on both wards. They had a ‘clean between’ campaign which encouraged staff to follow infection prevention and control measures between caring for different patients.

On the inspection we saw staff followed infection control principles. Staff cleaned equipment and furnishings in units and in rooms.

We saw that all staff were bare below the elbow, staff washed their hands before and after patient contact. Hand alcohol dispensers were accessible at the entry to each ward and on wards to reduce cross over contamination. Personal protective equipment such as aprons and gloves were available for staff to use if need be.

Cleaning records were generally up-to-date and demonstrated that all areas were cleaned regularly. Staff followed infection control measures using separate mop heads to stop cross contamination when cleaning floors.

Appropriate flooring was used on the wards and the flooring was easy to clean, reducing the likelihood of infection.

All patient areas and reception areas were clean and had suitable furnishings and were well-maintained.
Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. However, ward M1 was outdated and its environment had been placed on the risk register. We were told by patients that this ward could become cold dependent on the weather.

Staff were trained to use equipment and managed clinical waste well.

The medical wards we inspected consisted of ward M1 which was on the 1st floor and ward CRC which had access at the ground floor, both were in different parts of Clatterbridge Hospital.

Ward M1 was in an older part of the hospital and its design and interior space reflected its position. It was less modern than ward CRC and whilst it was functional and safe it looked very tired in places and in need of decoration and modernisation.

Staff responded quickly when we called at both wards. The wards had suitable facilities for caring for patients but ward M1 needed modernising, so it could better meet the needs of its patient's rehabilitation.

Reasonable adjustments were made to the buildings so that disabled people and those with low mobility could access and use services on an equal basis to others. Both wards we visited were accessible.

Patients could reach call bells on the wards and staff responded quickly when called and staff were close to patient's areas to respond to requests when needed.

The design of the environment and equipment mainly followed national guidance, rooms were of adequate specification and suitably sized.

We found ward CRC to be of a good standard in both its environment and equipment and the therapy department was well equipped and a suitable size.

The therapy room in ward M1 needed improvement and was not large enough, staff commented on the need to improve equipment and working space.

The ward environment on M1 generally needed improvements. M1 had no designated activity room for patients.

We were told by management that this was being addressed through the adaption of a staff room on the ward and were looking at other charitable organisation to help access furniture and equipment to make it suitable.

An activity room on ward M1 is an important feature because a large part of the role of rehabilitation units is social integration. The ward prepares individuals for life outside of hospital and it is a central part of the rehabilitation process. Patients had limited contact with each other and staff.

Whilst visiting Ward M1 we were also told by staff that they had issues with the heating of the ward. One complaint about the heating of the ward had been shared with us before the inspection and it was highlighted by staff and two patients, when we interviewed them, that the unit could get cold at night, especially in colder winter months.

The trust had placed the M1 ward environment on its risk register but the risk was not detailed and therefore the actions defined on the register were limited and not detailed enough in terms of addressing the problem.
The unit had responded to this by placing extra heaters on wards and providing extra blankets to patients. However, it was unclear to us how this situation will be managed in the future, especially in winter months.

Whilst it had identified that heating M1 was an issue, there was no system for monitoring the temperature on the ward, other than staff and patients complaining and the trust taking retroactive actions. A number of patients on the ward were frail and elderly and we felt it inappropriate for the trust to rely on patient feedback alone.

We found suitable toilets and bathing areas for patients and visitors on both wards. Toilet and bathing facilities were close to patient beds; all areas were single sex respecting dignity of patients. Whilst patients had access to bathing areas, we did find a broken bath on ward CRC with a sign attached identifying that the bath was broken and needed removing. We enquired how long the bath had been identified for removal and we were told it was first identified for removal at our last inspection in 2017. Therefore, the bath had been broken for a number of years on the ward before our inspection.

Staff had received training on using fire evacuation equipment. However, a fire escape outside the entrance to ward M1 had been partially blocked by equipment and a desk, despite the fire door stating, “please keep clear”. The obstruction was moved immediately during our inspection.

Staff carried out safety checks of specialist equipment defibrillators and resuscitation trolleys and their clinical waste were disposed of safely, through the trust and other contractors.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient and removed or minimised risks. We found that staff had the ability to assess and respond to patient risk and were aware of who to contact if deterioration occurred.**

Staff completed risk assessments for each patient on admission or arrival or reviewed risk assessments after any incident. The types of risk assessments included falls risks, nutrition and hydration and risk of developing pressure areas.

Plans were put in place if patients needed extra support in nutrition and weight and hydration was monitored through records. We reviewed the records for a number of patients on both wards and every patient had the risk assessments completed.

used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The records we reviewed showed that these had been correctly used.

Senior nurses monitored completion of deterioration reviews and other risk assessments electronically and audited the completion of risk assessments in their general audits of the two wards.

Patient falls, pressure ulcer instances and infection control issues were reviewed internally on wards and centrally by the trust.

Specialist equipment was available to reduce the risk of falls including bed side adaptations and assisted walking appliances.

Shift changes and handovers included all necessary key information to keep patients safe. The wards held a daily safety huddle, staff handover and multidisciplinary meetings. We observed one meeting and found that risks and needs of patients were discussed by professionals.
Staff understood the patient group they were working with and had good knowledge of individual patient’s needs and risks.

Staff told us they could seek medical advice and support from managers, doctors or consultants within the trust on a 24-hour basis.

Staff teams had access to mental health support for patients on both wards.

**Staffing**

**The service had enough staff with the right qualifications, skills, training and experience to keep people and adults safe from avoidable harm and to provide the right care and treatment. However staffing levels could be tight. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.**

We were able to talk to the staff about their view on their wards and if they felt they had enough staff at all grades to keep patients safe.

Staff told us that their teams and their own practice was safe and that risks were covered. The units were busy or extremely busy dependent on patient flow.

Staff told us that there was a strong ethos of supporting each other to cover what was needed to be done to make sure patients were safe and seen. Staff told us they could access cover internally or through agency workers when services needed support. Each profession relied on the other to improve patient health and eventual discharge.

Staff on both wards said staffing levels could be very tight particularly if staff were off sick or the service was particularly busy on that day. and when this occurred it could have a knock-on effect for patient care leading to patients not being ready for discharge.

We saw evidence on inspection that the managers and teams regularly discussed and reviewed staffing levels and skill mix, and all staff told us they received a full induction. Medical services were due to pilot a new staffing acuity tool in acute in November 2019 to help ensure there were adequate numbers of staff available at all times. During our inspection we observed that there were enough staff of each shift to care for patients.

We were told that managers attended a daily staffing meeting at 10am as part of the divisional safety huddle. Staffing levels for that day, the previous 24-hours and next 24-hours were reviewed and adjusted at that meeting.

**Nurse staffing**

**Trust level**

The table below shows a summary of the nursing staffing metrics in medical services at trust level compared to the trust’s targets, where applicable: Staff were not mapped consistently to sites, therefore staffing rates figures at site level do not total the trust figures.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Medicine annual staffing metrics</th>
<th>June 2018 to May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Nurse staffing rates within medical care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness, turnover, vacancy and bank usage rates.

**Agency staff usage**

Medical services had reducing rates of agency nurses used on the wards.

Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from August 2018 to January 2019. While agency use subsequently declined in the period following months from Feb to April 2019.

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

Information provided by the trust before the inspection did not breakdown staffing into sites. Therefore, not all information was available for medical services at Clatterbridge hospital.

Nurse staffing rates within medical services at trust level were analysed for the past 12 months and indications of improvement, deterioration or change were identified in monthly rates for sickness, turnover and bank use.

**Vacancy rate**
Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from October 2018 to February 2019. This could be an early indicator of deterioration.

Agency staff usage

Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from August 2018 to January 2019. While agency use subsequently declined in the period Feb to April 2019.

Clatterbridge Hospital

We asked the trust to provide evidence of sickness rates on both wards for a one-year period from November 2018 to November 2019. The sickness rates for both wards had fluctuated over the last 12 months particularly in the period of May, when the service had several staff off sick. We were told that long term sickness had been addressed and that the two wards only had short term sickness periods as of November 2019.

M1 ward had an average rate of sickness of between 8% to 9%, however this was impacted on by one member of staff being on long term sick.

CRC had a lower average rate of sickness between 5% and 7%.

The table below shows a summary of the nursing staffing metrics in medical services at Clatterbridge Hospital compared to the trust’s targets, where applicable:
## Medicine annual staffing metrics
### June 2018 to May 2019

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>129.3</td>
<td>0%</td>
<td>10%</td>
<td>4.0%</td>
<td>10,148 (17%)</td>
<td>NA</td>
<td>3,746 (6%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>42.5</td>
<td>22%</td>
<td>14%</td>
<td>7.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Nurse staffing rates within medical services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover or agency use.

### Sickness rate

**Sickness rate - qualified nurses, health visitors and midwives**

![Sickness rate chart](chart)

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives show a shift from December 2018 to May 2019.

### Bank usage

**Bank hours - qualified nurses, health visitors and midwives**

![Bank usage chart](chart)
Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives show a downward trend from August 2018 to December 2018. While bank use subsequently increased in the period Feb and March 2019.

Medical staffing

Trust level

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

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Medicine annual staffing metrics</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>June 2018 to May 2019</td>
<td>April 2018 to March 2019</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
<td>Annual sickness rate</td>
<td>Annual bank hours (% of available hours)</td>
<td>Annual locum hours (% of available hours)</td>
</tr>
<tr>
<td>Target</td>
<td>0%</td>
<td>10%</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>1,761.9</td>
<td>9%</td>
<td>10%</td>
<td>4.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>212.8</td>
<td>12%</td>
<td>12%</td>
<td>0.6%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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

Medical staffing rates within medical care at the trust were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness, bank or agency use.

Vacancy rates

Monthly vacancy rates over the last 12 months for medical staff show a shift from December 2018 to May 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
The table below shows a summary of the medical staffing metrics in medicine at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>129.3</td>
<td>13%</td>
<td>13%</td>
<td>6.5%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical staff</td>
<td>9.5</td>
<td>18%</td>
<td>0%</td>
<td>0.0%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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

Medical staffing rates within medical care at the trust were analysed for the past 12 months and there were no indications of improvement, deterioration or change identified in monthly vacancy, sickness, turnover, bank and agency rates.

Staffing skill mix

In March 2019, the proportion of consultant staff and middle career staff reported to be working at the trust were about the same as the England averages and the proportion of junior (foundation year 1-2) staff was higher than the England average. The proportion of the registrar group staff was lower than the England average.

Staffing skill mix for the 146 whole time equivalent staff working in medicine at Wirral University Teaching Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>48%</td>
<td>45%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>17%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>28%</td>
<td>20%</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 (March 2019))
Records

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

The quality of records was good across the wards. Staff used a mixture of both electronic but mainly paper records.

Record were also reviewed as part of both wards' internal audits, which were undertaken by senior managers.

The records we reviewed were mainly clear and concise in terms of interventions made by staff and the recording systems supported patient care.

Patient notes were overall comprehensive, and all staff could access them easily. The records included clear evidence of information on medications and timelines and assessments were recorded. Electronic notes were accessed by password for confidentiality.

Since our last inspection of medical services at the trust’s Arrowe Park site, the service had introduced new lockable records trolleys and we found this to be the case in Clatterbridge site. Records were kept in secure settings and could not be accessed by patients or visitors to the units. Previous paper records were archived in a secure place.

Medicines

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

As part of our inspection we reviewed how medication was given to patients by staff and recorded. We found that controlled drugs were stored correctly and daily checks had been undertaken. The clinic rooms were clean and tidy with no medication left unsecured. Ambient room temperatures were checked daily on most occasions.

Patients wore red wrist bands if they had a allergy to a medication to alert staff to check their records before administering medication.

The trust had a medicines management policy and staff within the wards followed systems and practices in relation to the policy.

As well as following guidelines, the service had access to a pharmacist and a pharmacy technician who supported medicine management.

The trust used an electronic prescribing and administration system. Alerts on the system meant that staff could prioritise patients and ensure medicines were given at the right time. Patients had their medicines venous thromboembolism (VTE) risk assessments completed and appropriately recorded.

Medicines were kept in secure settings and recording systems were in place to monitor use. The service followed medicines management guidelines outlined by the trust for the refrigeration of medicines and recorded fridge temperatures appropriately.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
When things went wrong, staff apologised and gave patients suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff on both wards used an electronic system to monitor and report incidents, which fed into a trust wide system and all staff had access to it.

Staff recognised and could describe incidents and safety concerns appropriately, including near misses. All staff we spoke with knew which incidents to report and how to report them.

The highest occurring type of incident on the medical wards in Clatterbridge was from falls, trips and slips. The patients on the ward were on rehabilitation programmes and therefore many of them were facing the challenge of walking after being off their feet for some time. This meant there was a known risk of slips and falls occur.

We saw evidence that incidents particularly fall incidents were reviewed internally, and learning was shared with staff and the larger trust.

Staff told us they were open and honest when incidents occurred and understood the duty of candour.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

**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 July 2018 to June 2019, the trust reported no never event for medicine at Clatterbridge.

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

**Breakdown of serious incidents reported to STEIS**

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported 17 serious incidents (SIs) in medical services which met the reporting criteria set by NHS England from July 2018 to June 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls</td>
<td>6</td>
<td>35.3%</td>
</tr>
<tr>
<td>Diagnostic incident including delay (including failure to act on test results)</td>
<td>3</td>
<td>17.7%</td>
</tr>
<tr>
<td>HCAI/Infection control incident</td>
<td>3</td>
<td>17.7%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>Medication incident</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>Pending review (a category must be selected before incident is closed)</td>
<td>1</td>
<td>5.9%</td>
</tr>
</tbody>
</table>
Clatterbridge Hospital

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in medical services which met the reporting criteria set by NHS England from July 2018 to June 2019.

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 56 new pressure ulcers, 49 falls with harm and 52 new urinary tract infections in patients with a catheter from May 2018 to May 2019 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Wirral University Teaching Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Total Pressure ulcers (56)</th>
<th>Total Falls (49)</th>
<th>Total CUTIs (52)</th>
</tr>
</thead>
</table>

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

(Source: Strategic Executive Information System (STEIS))

(Source: NHS Digital - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service participated in a number of clinical audits as part of an ongoing clinical audit programme.

Medical and nursing staff followed National Institute for Health and Care Excellence (NICE) guidance and had introduced nationally recognised learning promoted through National Health Service Innovation.

One of the main ways the wards reviewed effectiveness was through a system called “perfect ward” audits.

The audits measure the safety and quality of nursing care delivered by teams and was supported by senior nursing staff who checked set criteria which were scored independently and then collectively to reach a final ward score.

The audits included questions on environment, medicines and patient care. The trust provided us with audits from both wards which included data from September to November 2019. The audits are conducted using a traffic light process where services are RAG rated i.e. red, amber or green, green being the standard to reach.

In total we reviewed three audits and out of those, only one audit in September 2019 on ward M1 dipped below green to amber at 82%. All the other five audits across both M1 ward and CRC achieved a green rating and ranged between 91% and 96%. None of the wards showed any significant areas of concern or repeated failures.

We found that both units have instances of falls. The likelihood of falls on rehabilitation units is high given the type of patients that stay on the wards. Many patients on the units are frail or have a disability and are being encouraged to be mobile and independent. The units told us they were committed to reducing falls by adopting a falls bundle which is audited through the perfect ward audit. The bundle included the use of cognitive assessments, review of medication and the use of fall precautions such as bed rails and sensor pads to alert staff. On review of the perfect ward audits results were positive with all falls bundle reviews at a RAG rating of green.

The unit participated in a falls panel which reviewed falls incidents across the trust and made recommendations that were shared for learning. Pressure ulcers and infection outbreaks were also reviewed in the same way.

The wards managed sepsis through the sepsis six pathway in line with NICE guidance. The sepsis six care pathway is a part of the UK Sepsis Trust's recommended approach to diagnosing and treating sepsis. The pathway targets the reduction of the number of people who die unnecessarily from sepsis in the UK each year.

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 adjusted for patients’ religious, cultural and other preferences.

Staff used the malnutrition universal screening tool, which is a nationally recognised tool for assessing potential malnutrition. Fluid nutrition charts were used for patients when necessary.
Specialist support from dieticians and speech and language therapists were available for patients who needed it and all patients with a malnutrition universal screening tool below 2 were referred to a dietician as standard.

Patients hydration and nutritional support needs were monitored so that staff could assist them where necessary.

Patients were given a variety of foods for breakfast lunch and dinner which were culturally specific, and food was served in the canteen or in rooms dependent on the patient's mobility.

Patients told us they were given enough food to eat and drink and we saw evidence of water in jugs ward areas so that patients could receive hydration.

The units had a patient cooking area, where patients could cook their own snacks or drinks.

We saw evidence in perfect ward audits that nutrition and hydration was assessed and provided to patients including adjustments.

**Pain relief**

*Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way and gave additional pain relief to ease pain.*

Staff had access to a nationally recognised pain scoring system and we were able to review records that showed patients pain scores were monitored effectively by staff.

Patients told us they received pain relief quickly and were asked about it regularly by medical and nursing staff.

**Patient outcomes**

*Whilst staff monitored the effectiveness of care and treatment and used the findings to make improvements, the service did not take part in national patient outcome audits to help improve patient outcomes. There was also a higher relative risk of readmission in some areas.*

The two wards did not independently participate in national patient outcomes. As well as perfect ward audits the wards carried out an audit plan with other medical wards which included review of quality assurance, record keeping vital signs in adults and venous thrombolism risks in lower limbs.

Audits were conducted by using a set questionnaire which includes national medical standards. The audits were conducted using a traffic light process where services were rated red amber or green, green being the standard to reach. Audits which had not started were deemed as white.

The trust sent us the audit results for the medicine directorate in the period April to June 2019. Audit results were collective across medical services and not broken down into ward results. However, the results of the audits were positive. In total five of the seven ongoing audits showed green in the period. The other two audits had not started.

**Relative risk of readmission**

**Trust level**

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

**Elective admissions – Trust level**
• Patients in gastroenterology and respiratory medicine had a higher than expected risk of readmission for elective admissions
• Patients in clinical haematology had a lower than expected risk of readmission for elective admissions

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

Non-elective admissions – Trust level

• Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
• Patients in geriatric medicine and respiratory medicine had a similar to expected risk of readmission for non-elective admissions

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

Clatterbridge Hospital

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

Elective admissions - Clatterbridge Hospital

• Patients in dermatology had a higher than expected risk of readmission for elective admissions
• Patients in nephrology had a much higher than expected risk of readmission for elective admissions

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

Non-elective admissions - Clatterbridge Hospital
• Patients in Rehabilitation had a similar to expected risk of readmission for non-elective admissions
• Patients in geriatric medicine and dermatology had a much higher than expected risk of readmission for non-elective admissions

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

(Source: Hospital Episode Statistics - HES - Readmissions (February 2018 to January 2019))

Clatterbridge Hospital

Clatterbridge Hospital does not participate in the Sentinel Stroke National Audit programme.

(Source: Royal College of Physicians London, SSNAP audit)

National Diabetes Inpatient Audit

Wirral University Teaching Hospital NHS Foundation Trust did not participate in the 2017 National Diabetes Inpatient Audit.

(Source: National Diabetes Audit 2017)

Lung Cancer Audit

The table below summarises Wirral University Teaching Hospital NHS Foundation Trust’s performance in the 2018 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist (Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</td>
<td>87.0%</td>
<td>Does not meet the audit aspirational standard</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Case-mix adjusted one-year survival rate (Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td>39.6%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery (Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>16.2%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment (For fitter patients with incurable NSCLC anti-cancer treatment is known)</td>
<td>74.1%</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>Metrics (Audit measures)</td>
<td>Trust performance</td>
<td>Comparison to other Trusts</td>
<td>Met national standard?</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>----------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>81.8%</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
</tbody>
</table>

(Source: National Lung Cancer Audit 2018)

National Audit of Inpatient Falls

Clatterbridge Hospital

Clatterbridge Hospital did not participate in the 2017 National Audit of Inpatient Falls.

(Source: National Audit of Inpatient Falls 2017)

Chronic Obstructive Pulmonary Disease Audit

Clatterbridge Hospital

Clatterbridge Hospital did not participate in the 2018/19 Chronic Obstructive Pulmonary Disease Audit.

(Source: Chronic Obstructive Pulmonary Disease Audit 2018/19)

National Audit of Dementia

Clatterbridge Hospital

Clatterbridge Hospital did not participate in the 2017 National Audit of Dementia.

(Source: National Audit of Dementia 2017)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance to provide support and development.

Appraisal rates
All staff we spoke with told us that they had access to appraisal. The data we did receive from the trust showed appraisal completion rates were higher than the target compliance rate across both nursing and medical staff in the Clatterbridge site.

However, administration staff appraisal rates needed some improvement to reach the trust compliance target.

The breakdown by staff group can be seen in the table below

**Trust level**

From April 2018 to March 2019, 88.3% of staff within medicine department at the trust received an appraisal compared to a trust target of 88%.

A breakdown of appraisal completion rates by staff group is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>115</td>
<td>121</td>
<td>95.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>165</td>
<td>185</td>
<td>89.2%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>393</td>
<td>442</td>
<td>88.9%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>455</td>
<td>517</td>
<td>88.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>148</td>
<td>172</td>
<td>86.0%</td>
<td>88.0%</td>
<td>No</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>1</td>
<td>13</td>
<td>7.7%</td>
<td>88.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

**Clatterbridge Hospital**

From April 2018 to March 2019, 94.5% of staff within medicine department at the trust received an appraisal compared to a trust target of 88%.

A breakdown of appraisal completion rates by staff group is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>41</td>
<td>41</td>
<td>100.0%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>29</td>
<td>30</td>
<td>96.7%</td>
<td>88.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>25</td>
<td>30</td>
<td>83.3%</td>
<td>88.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

**Multidisciplinary working**
Doctors, nurses and other healthcare professionals did not consistently work together as a team to benefit patients.

Internally the units had good levels of handovers usually three shift patterns morning, afternoon and night shifts. The wards had access to occupational therapist, physiotherapists therapy assistants and social care staff.

We saw staff using a multidisciplinary integrated care pathway and we saw good communication between differing types of professionals with a targeted goal of moving patients back into communities safely. Therapy staff worked five days per week.

Whilst this was the case there was some concern that pressure on staffing in differing services reduced the overall performance of the service. We were given examples by staff of delays in discharging patients because staff from partner organisations were not always available to work with staff in the services to facilitate effective discharge of patients. The staff on ward M1 told us that therapy staffing was down by one member due to sickness.

Staff told us that discharges had previously been put on hold for weeks because of lack of staff from other areas to work in a multidisciplinary way.

Whilst this was the case we found clinical staff, nurses and support staff were actively involved in discussing patient care and this included staff huddles which were used to discuss issues which had occurred throughout the day.

Staff held regular multidisciplinary meetings to discuss patients and improve their care, but some felt that the push to discharge staff had become as big a driver as patient care.

Seven-day services

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

Wards had access to consultants and doctors, including weekends on both wards.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There was 24 hour a day on call consultant cover.

Therapy services which included occupational health and physiotherapy were available for patients five days a week.

Health promotion

The wards assessed each patient’s needs when they were admitted and provided support dependent on the assessment, so they could lead a healthier lifestyle. We did not see any leaflets available about health awareness and support groups.

We found several examples during the inspection where patients were supported to increase mobility through involved in games and activities.

Staff talked to patients about how they could reduce their risk of falling both during their admission and at home.

Staff and activity co-ordinators arranged events which, which helped stimulate mental health and wellbeing.

Staff described looking at how patients could maintain social stimulation once they returned home.

We did not see leaflets in any wards about health awareness and support groups, and healthy eating and fitness clubs.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Training levels were high amongst nursing staff. However, the directorate did not provide us with robust evidence that staff knew if there was an effective system for tracking and monitoring deprivation of liberty safeguards across its nursing staff.

Staff on both wards understood how and when to assess whether a patient had the capacity to make decisions about their care and had access to support to achieve this.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients’ records.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

The trust did not provide any data for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training for medical services.

Following our inspection, the medicine directorate told us that this training is included in all levels of the protecting vulnerable people training.

Compliance with this training for nursing staff was over 95%.

The service told us the safeguarding team provide bespoke training to ward staff during walk rounds and when requested by staff or a ward.

The safeguarding team monitored the use of Deprivation of Liberty Safeguards and mental capacity assessments.

However direct feedback to staff was done by adding to records rather than email or face to face communication, therefore there was a danger that authorisations might expire or be missed.

We saw these were not monitored through matron or associate director of nursing audits, as part of perfect ward audits.

Following our inspection, the medical directorate service told us for every seven-day urgent application submitted the safeguarding team also requested an extension to ensure the authorisations do not expire.

They provided information that showed they submitted 356 DoLS applications between August and October 2019. Of these 341 required an extension and 27 had an extension expiry date recorded.

We were told that some staff groups, such as allied health professionals, did not receive Mental Capacity Act and Deprivation of Liberty Safeguards training.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
Staff on both wards demonstrated a good understanding of people’s needs particularly in terms of patients being separated from their family and home environments.

We found that the care on the units by individual staff was good, however rehabilitation could have been prioritised better.

M1 in particular had issues with getting people to live as they did in the community and moving away from a ward or hospital environment as soon as possible.

The two wards had no access to activity coordinators for instance, who could support patients’ rehabilitation.

We were told of actual improvement on ward M1 where staff and patients praised new management on the ward for changing the caring environment for the better.

An example of this was the ward manager moving office from a corridor to directly facing the wards, so that she could directly monitor and support her staff who were providing care to patients.

Staff were discreet and responsive when caring for patients in both wards and they took interest in patients’ conversations and sat a listened to patients in their conversations.

Staff describe differing care needs of patients and showed understanding and a non-judgmental attitude when caring for, or discussing, patients who were vulnerable.

We were told that staff made a concerted effort to specifically meet the needs of patients who had no visitors or family support networks.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

All the families we spoke to felt supported by staff and all said they felt that their loved ones were cared for respectfully. We spoke to five patients who told us care was good and staff were considerate.

**Friends and Family test performance**

The Friends and Family Test (FFT) is an important feedback tool that provides feedback on patient experience. The test asks people if they would recommend the services they have used and offers a range of responses.

From June 2018 to May 2019, the Friends and Family Test response rate for medicine at the trust was 19%, which was lower than the England average of 24%.

The number of responses to the questionnaire in Clatterbridge was 3 times higher than its equivalent medicine wards in Arrow Park but positive responses were still over 90%.

The table below shows the response rate by site:

<table>
<thead>
<tr>
<th>Location/site</th>
<th>Number of responses</th>
<th>Response rate</th>
<th>Annual performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrowe Park Hospital</td>
<td>2,810</td>
<td>18%</td>
<td>98%</td>
</tr>
<tr>
<td>Clatterbridge Hospital</td>
<td>208</td>
<td>62%</td>
<td>90%</td>
</tr>
<tr>
<td>Total</td>
<td>3,018</td>
<td>19%</td>
<td>97%</td>
</tr>
</tbody>
</table>

The table below shows both the response rate by ward and the percentage of patients on those wards that would recommend the service to friends or family:
7. 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), as well as wards where there were less than 100 responses in total over the 12 month period.

8. Sorted by total response.

9. 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.

From June 2018 to May 2019:
- Annual performance for all wards was between 88%-100%
- Endoscopy had the lowest response rate (11%), which it accounted for 26.8% of all responses across the medical wards.
- Ward M1 (rehabilitation) had the highest response rate (51%), which it accounted for 3.5% of all responses across the medical wards.
- Ward 23 (geriatric medicine) scored the highest, with 100% patients recommending the service in 11 months of the year.
- The lowest annual percentage recommended was for ACU, with recommendations lowest at 60% in March 2019.

(Source: NHS England Friends and Family Test)

Emotional support

Staff recognised the specific needs of patients and were sensitive and discreet in their practice.

Staff on both wards described the emotional support they provided to patients in the units.

Staff told us how they supported patients and families who had faced upheaval in their lives due to illness.

We were told that potentially distressing news or difficult conversations took place in safe or confidential environments, helping the patient or the patient's families to maintain their privacy and dignity.

Staff understood the emotional and social impact that treatment or a condition had on patients and their family's wellbeing and acted as advocates for patients in both community-based services and acute settings.

Staff described referrals to other agencies which could support patients issues in the community when they left the units.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
Staff made sure patients on the two wards understood their care and treatment and described how they supported patient understanding of treatment verbally.

Staff supported patients to make advanced decisions about their care. Staff told us they tried to discuss treatment in a way that patients understood using communication and visual aids where necessary.

We reviewed patients records where staff had explained future treatment in the service, so that patients were aware of next steps.

Staff followed policy to keep care and treatment confidential, however family members were appropriately consulted with by staff members.

Patient’s families praised staff and spoke warmly about the support they received from staff. Family members were involved in future care planning and feedback from individuals was positive.

Patients could give feedback on the service and their treatment and staff supported them to do this.

**Is the service responsive?**

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

The service planned and provided care in a way that at times did not consistently meet the needs of local people and the communities served. It sometimes did not work effectively with others in the wider system and local organisations to plan care. Not all facilities and premises were appropriate for the services being delivered.

In many instances we found the services individual staff and staff groups were responsive to need, rather than the system itself being responsive.

All staff worked towards the benefit of patients but the system to discharge patients was fragmented and complex, with too many pathways each working separately towards their own aims.

We were able to talk to staff about how medical care and social care interacted together and in a number of cases the response was negative.

We found a lack of social care staff at specific times in the year, staff had no cover and work was not addressed whilst leave was taken, leaving backdated referrals or assessments to be addressed, further delaying transfer.

Staff were frustrated because patients and their families were given options for accommodation and not enough placements were available for the options which were attractive. We were told delays of weeks occurred whilst patients' families made appeals about family member’s placements after potential discharge because they were not happy with placement decisions.

Integrated discharge team worked on wards but not as part of the ward and we saw a general lack of a collective vision.

Not all facilities and premises were appropriate for the services being delivered particularly on ward M1 and the therapy areas needed to be improved.

Therapy services in ward CRC had space and equipment whilst ward M1 had only room for one or patients at a time, clearly impeding the number of patients who could be seen in a day.

All the ingredients of a responsive service were apparent in the ward areas. There was clearly a multidisciplinary team available including speech and language therapists, physiotherapists and occupational therapists to facilitate discharge from hospital. However, at ward level we were unclear as to who the final decision maker was so that systems worked.
Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff we spoke with stated mixed sex breaches were rare.

Meeting people’s individual needs

The service was inclusive, and staff made reasonable adjustments to help patients access services. However, there was a risk that the environment may have an impact on patients achieving their personal goals.

Care plans in patient records on both wards did include person centred goals but there was a risk that the delivery of the identified outcomes may not always be achieved. This was due to the layout of the environment not always helping support rehabilitation goals.

The wards were not tailored to meet the needs of patients who were going through rehabilitation and this was particularly evident in ward M1.

Access to therapy services was limited by the design and size of rooms and this had an impact on patient rehabilitation goals. Patient communication on the ward was also limited because the ward had no resource for patients to meet with each other and staff.

Staff could access emergency mental health support for patients with mental health problems, learning disabilities and dementia. The wards provided dementia friendly facilities and staff supported patients living with dementia well.

The service also worked well with end of life organisations and the palliative team.

Interpretation and sign language were available for staff, patients, loved ones and carers so each could get support.

Patient leaflets were not available on wards in any language including English.

Access and flow

People could not always access the service when they needed it and care and treatment was not always provided promptly. We found that waiting times from referral to treatment were consistently lower than national standards.

It was clear during the inspection that the wards were struggling to cope with discharging patients promptly.

On our inspection we reviewed a monitoring board which was place on ward M1. We found that half of the 36 patients on ward M1 had failed to reach their intended discharge date.

We tried to review the numbers of patients on CRC who had not met the intended discharge, but the information was not available.

We were told by managers in the directorate that they monitored patient transfers. During our inspection we attended a bed management meeting and saw all patient transfers to wards at Clatterbridge Hospital were discussed. However, no staff from the Clatterbridge Hospital attended the meeting. We requested information on the number of patients transferred or discharged to Clatterbridge Hospital. Unfortunately, the service was not able to provide this. We were therefore, not assured that there was oversight on the access to the service.
The trust also told us that it had commissioning targets for rehabilitation. We asked the trust to provide us with any targets they had in the areas of rehabilitation both internal and external after the inspection, but we did not receive any. It was therefore not possible to assess if these were having any impact on access to services and discharge for patients.

**Average length of stay**

**Trust level**

From March 2018 to February 2019 the average length of stay for medical elective patients at Wirral University Teaching Hospital NHS Foundation Trust was 15.2 days, which is much higher than the England average of 5.9 days. For medical non-elective patients, the average length of stay was 7.0 days, which is higher than the England average of 6.1 days.

Average length of stay for elective specialties:
- Average length of stay for elective patients in gastroenterology is similar to the England average.
- Average length of stay for elective patients in respiratory medicine is lower than the England average.
- Average length of stay for elective patients in dermatology is much higher than the England average.

**Elective average length of stay – Trust level**

Average length of stay for non-elective specialties:
- Average lengths of stay for non-elective patients in general and respiratory medicine are both lower than the England averages.
- Average length of stay for non-elective patients in geriatric medicine is higher than the England average.

**Non-elective average length of stay – Trust level**

**Clatterbridge Hospital**

From March 2018 to February 2019 the average length of stay for medical elective patients at Clatterbridge Hospital was 25.9 days, which is much higher than England average of 5.9 days. For medical non-elective patients, the average length of stay was 70.3 days, which is much higher than England average of 6.1 days.
Average length of stay for elective specialties:

- Average lengths of stay for elective patients in dermatology, nephrology and rehabilitation are all much higher than the England averages.

**Elective average length of stay - Clatterbridge Hospital**

![Graph showing elective average length of stay]

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

Average length of stay for non-elective specialties:

- Average lengths of stay for non-elective patients in rehabilitation is much higher and geriatric medicine are is higher than the England averages.
- Average length of stay for non-elective patients in nephrology is lower than the England average.

**Non-elective average length of stay - Clatterbridge Hospital**

![Graph showing non-elective average length of stay]

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

(Source: Hospital Episode Statistics)

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

From June 2018 to May 2019, the trust’s referral to treatment time (RTT) for admitted pathways for medicine was consistently lower than the England average. February 2019 saw the worst performance of 30.4% compared to 87.2% England average.

![Graph showing referral to treatment (percentage within 18 weeks)]

(Source: NHS England)

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

The following two 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>General Medicine</td>
<td>100.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>97.0%</td>
<td>96.6%</td>
</tr>
</tbody>
</table>

The following five specialties were below 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>Thoracic Medicine</td>
<td>91.7%</td>
<td>94.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>72.3%</td>
<td>81.0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>66.3%</td>
<td>92.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>60.8%</td>
<td>81.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>54.5%</td>
<td>95.0%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Patient moving wards per admission

We were told that only two patients moved wards in the last year and then were transferred back. (Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

The trust provided information on both wards' night moves between October 2018 to October 2019. Ward M1 had no recorded transfers between those two dates and CRC had 2 moves recorded.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns and whilst we were on inspection, we saw a relative’s complaint being dealt with by the ward manager.

However, we did not see information clearly displayed on wards on how to raise a concern.

Staff told us they tried to deal with complaints on an informal basis if they were low risk or reasonable, however they were clear that complaints would be resolved formally when needed.

From July 2018 to June 2019, Clatterbridge site, where both wards are situated, received only five complaints.

Summary of complaints

Trust level

From July 2018 to June 2019, the trust received 77 complaints relating to medical care (33.6% of total complaints received by the trust). The trust took an average of 34.1 working days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be dealt with within 30 working days.

However, the trust target for completing complaints prior to December 2018 had been 25, 45 or 60 working days (depending upon complexity).

A breakdown of complaints by type is shown below:
<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment and procedure</td>
<td>25</td>
<td>32.5%</td>
</tr>
<tr>
<td>Communication</td>
<td>21</td>
<td>27.3%</td>
</tr>
<tr>
<td>Medication</td>
<td>7</td>
<td>9.1%</td>
</tr>
<tr>
<td>Transfer and discharge</td>
<td>6</td>
<td>7.8%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>5</td>
<td>6.5%</td>
</tr>
<tr>
<td>Tests and results</td>
<td>4</td>
<td>5.2%</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>3</td>
<td>3.9%</td>
</tr>
<tr>
<td>Access and admission</td>
<td>3</td>
<td>3.9%</td>
</tr>
<tr>
<td>Patient slip, trip or fall</td>
<td>2</td>
<td>2.6%</td>
</tr>
<tr>
<td>Documentation</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>77</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

A breakdown of complaints by site is shown below:

<table>
<thead>
<tr>
<th>Location/Site</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrowe Park Hospital</td>
<td>66</td>
<td>85.7%</td>
</tr>
<tr>
<td>Clatterbridge Hospital</td>
<td>5</td>
<td>6.5%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>4</td>
<td>5.2%</td>
</tr>
<tr>
<td>St Catherine’s Hospital</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td>Victoria Central Hospital</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>77</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**

From July 2018 to June 2019, there were 25 compliments relating to medicine (19.5% of total compliments received by the trust).

A breakdown of compliments by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrowe Park Hospital</td>
<td>22</td>
<td>88.0%</td>
</tr>
<tr>
<td>Clatterbridge Hospital</td>
<td>3</td>
<td>12.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

**Is the service well-led?**

**Leadership**

Leaders had the integrity, skills and abilities to run the service and this was being done whilst teams and the whole service were going through transitional changes, including job roles. They understood and managed the priorities and issues the service faced and sought support to enhance leadership. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The Clatterbridge site leadership arrangements were covered by the medicines department which included Arrowe Park.
Leaders were visible and approachable in the service for patients and staff. Staff told us that divisional leaders and managers were visible and approachable. Managers felt supported by leaders and told us they saw them daily at bed meetings.

The service was led by triumvirate of divisional director of nursing, divisional director and an associate medical director. Leaders told us the involvement of medical leadership in quality issues and improvement plans had improved since our last inspection. They gave examples of support offered to junior doctors from medical leaders.

Leaders supported staff to develop their skills and take on more senior roles.

Matrons spoke highly of support from divisional leadership and stated development opportunities for staff had improved at ward level. There was also a development programme for ward sisters which some had attended.

At ward level, it was clear there had been a period of instability, which had been addressed by senior managers by introducing a new leadership team on ward M1.

We were impressed by the new leadership on the ward and the immediate actions which were being implemented to increase morale and boost teamwork.

Management had clearly identified improvements which needed to be made. The new ward management team had quickly clearly defined the priorities and had already began to action some of their aims and objectives.

It was clear that members of the staff group on ward CRC were also positive about the future of the local leadership and fully supported them.

It was clear on inspection that the senior leadership need to ensure the new leadership team is nurtured and supported to grow.

Staff told us that issues were dealt with and leadership responded quickly and positively when required. The staff told us they were aware of who managed the service and the management structure. They were kept up to date with progress in the directorate through direct feedback from managers in team meetings. The staff told us they were communicated with in both wards we visited.

**Vision and strategy**

The trust had created a set of clear visions which were widely displayed throughout the service and which staff could clearly articulate. However, these were not supported by a clear organisational strategy or a clear strategy on rehabilitation.

The Clatterbridge site vision and strategy were covered by the medicines department which included Arrowe Park.

The divisional strategy was described as 'to provide high quality and safe care across all areas by utilising best practice, the skillset of all staff members and the opportunities presented through technology' and to 'empower its workforce to develop sustainable improvements in care, patient flow and communication flow pathways'.

The divisional strategy was described by leaders as a work in progress. The service held a divisional strategy away day for staff of all grades and disciplines. It had also held away days at speciality level with involvement of all staff. From this staff engagement, the service had drawn up divisional
priorities with associated action plans. We reviewed the strategy statement and saw it covered key areas of workforce, quality and safety, unplanned patient flow, planned patient flow and finance.

However, leaders acknowledged that the divisional strategy sat in isolation and was not linked to an overall trust strategy as this was not yet in place.

There was no evidence of a strategy for rehabilitation services which the service delivered at Clatterbridge hospital.

**Culture**

**Staff satisfaction was generally good. The service gave staff opportunities to raise concerns or provide feedback. However, some staff groups told us that the previous year had been difficult, but they now felt respected, supported and valued.**

Leaders reported culture medical services had improved overall. The service used culture reviews to identify cultural issues within teams and departments.

Staff on both wards felt able to speak up and they had seen changes as a result of a cultural review within the service. Staff were given open and honest feedback following these reviews which increased their trust in the organisation.

We were provided with a plan of action which stemmed from a cultural review of ward M1 from June 2019 to June 2020. The work streams covered a wide range of areas including staffing structure, acuity of patients' communication and environment and resources. Whilst the plan was in its early stages it was positive to see that actions were on track and being addressed collectively.

Managers reported that support from trust leadership to divisional and service level was good.

We found that at times staff were really busy providing services to patients and they had little time to reflect on practice but overall all staff we talked to had great pride in the services they delivered. The staff group as a whole, were strong advocates for getting patients back into communities and out of hospital.

Managers told us that in the last 12 months staff attitude towards quality improvement had changed and there was now an openness to ideas and a willingness to engage in improvement projects. The service nominated teams and individuals for the trust ‘Together Awards’ to recognise good practice.

Staff we spoke with were aware of the role of Freedom to Speak Up Guardian and knew who they were and how to contact them.

**Governance**

**Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. We found local governance processes were effective across the medicine department in the two wards at Clatterbridge.**

The Clatterbridge sites governance arrangements were covered by the medicines division which included Arrow Park.

At our last inspection at Arrow Park, in which we did not visit Clatterbridge, we highlighted a number of ‘must’ and ‘should’ actions for the medical division as a whole.

We told the service it must ensure that patient records were always kept secure. At this inspection which also covered Clatterbridge, we found record trolleys containing patient records were secured on both Clatterbridge wards.
Leaders in the medicine department also told us that they had made improvements including gaining access to data to enable them to analyse performance through perfect ward and matron audits and we gained access to some of this data in the inspection and reviewed it positively.

The division was divided into four directorates each with its own triumvirate of leaders and governance structures. Divisional patient safety and quality boards had a representative from each directorate.

The clinical directors, medical director and divisional director meet weekly as a leadership team to review performance.

Managers attended a monthly divisional performance review meeting where key targets and patient flow were reviewed, as well as the divisional dashboard.

Information from patient safety and quality boards and the harms panel reports were also reviewed at the performance review meeting.

We were told matrons reported oversight by triumvirate at divisional level and had improved governance structures.

Matrons stated governance meetings were useful and involved all members of the team to improve risk management.

Managers on both wards told us the service felt safe and they were tied into structures locally and within the trust.

The service reviewed mortality and morbidity through the structured judgement review process. Every death in the service was allocated to a consultant for an initial review who then identified any issue which meant the death should be reviewed through this process. Mortality reviews are important as they facilitate learning from deaths that have happened in the department, particularly when a death may have been avoidable.

Management of risk, issues and performance

Though leaders and teams used systems to manage performance, these were not always clear or effective. Staff could identify risks for the service, but we found there was little local ownership of risks and actions.

The Clatterbridge sites risk management was covered by the medicines division which included Arrow Park.

Once risks were identified at ward level in both sites, the risk department was responsible for ensuring the risk was added to the divisional risk register.

Managers in the medicine department told us in the inspection that the risk department followed up any actions either on the review date identified or after six months.

The divisional director of nursing and senior nurses met weekly with the divisional risk management team to review severe and moderate risks and escalated these to the divisional risk committee through the patient quality and safety board. The weekly associate director of nursing reports identified all incidents and outstanding risks, and a risk reminder was sent electronically to risk owners to highlight when an action was due.

The one risk register action identified in the two wards was on ward M1 and related to the inability to maintain the ward at an optimal environment due to the age of the building.

The risk itself was too generic and therefore it was unclear how specific issues were going to be dealt with and monitored.
The first date of the risk being put on the register was unclear, and the second date was April 2020 and therefore we were unsure as to the actual gap between the two reviews.

The ward had recently undergone a cultural review where the environment and other issues regarding patient and nursing care had been discussed, however none of the issues were on the register and the review was not mentioned at all. We would have expected to see the escalation of those issues highlighted in the register also.

We reviewed the risk register for medicine as a whole and found the register did not always fully mitigate the risk or risks were not acted on in a timely manner. We reviewed the risk register and saw that not all risks identified had action to address the risk, target dates or persons responsible assigned to actions. One risk for general medicine stated no controls were in place and no progress had been made, another had no action plan. A risk relating to replacement of call bells had a target date of 2029.

Managers and leaders attended a daily divisional safety huddle which included a review of incidents, risks and staffing for the previous 24-hours and the next 24-hours. There were also daily safety huddles on each ward to share information at ward level.

There was a trust wide safety summit open for any member of staff to attend and individuals were encouraged to present at this. However, staff told us it was difficult for ward-based staff to attend as they could not get time away from the ward.

The service had a system of weekly monthly and quarterly audits as part of perfect ward audits. However, this was a relatively new system across medicine and not yet fully embedded. Weekly audits were completed by ward sisters and were a mix of record checks and observational audits. These were followed by monthly matrons audit and quarterly audits by the associate directors of nursing.

These audits were reviewed every month as part of a perfect ward audit meeting attended by the divisional directors of nursing and themes identified and action plans put in place.

The service had a falls steering group which developed and monitored the falls improvement plan. This was attended by doctors, nurses and therapy staff and met every eight weeks to review progress on improvement plan.

Information management

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

Staff on both wards accessed records electronically and by paper, access to electronic records could be made via clinic computer systems. Paper records were securely kept in trolleys and secure rooms when not being used.

We found all electronic information systems were securely protected by password to prevent access outside of the team.

All polices were accessed via the trust electronic system and staff were aware how to access information. Managers and staff could access alerts and incidents.

Managers had access to the risk register and could notify local and national partners on concerns including serious incidents.
Service performance documentation was available online through the trust so that staff could review performance.

**Engagement**

Leaders and staff actively and started to openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff we spoke to on ward M1 and CRC, felt they had good access to senior staff and that their ideas were listened to and if feasible ideas were now being implemented.

It was clear from the cultural review undertaken in April 2019, that moral and staff engagement on ward M1 had been poor. However, management had taken positive steps in asking the 42 staff individually what they wanted to see change on the ward. Staff had come up with six objectives which had been progressed by senior managers and had been reviewed by ward managers in conjunction with the staff group. We could see during the inspection that staff had been consulted and change had started to occur.

We were told that the engagement work helped to keep the team focused, engaged, and promotes a continuous feeling of ‘teamwork’ which helps to improve service delivery and retain core staff members to the unit.

**Learning, continuous improvement and innovation.**

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

Since our last inspection the service had completed a number of quality improvement projects across its medicine department. For example, the service had worked to improve compliance with nutritional screening on wards. The service had a number of continuous improvement projects such as length of stay and falls.

The falls prevention group were reviewing alternatives to sleep medication to reduce falls at night such as introducing eye masks and lavender pillows. Managers told us that all matrons had been booked onto a quality improvement training course. The service had introduced a ‘bright ideas’ email for all staff to share any ideas they had for quality improvement projects or to improve the patient experience. The service used ‘quality buses’ on wards to promote improvement projects or awareness campaigns.

**Management of risk, issues and performance**

Though leaders and teams used systems to manage performance, these were not always clear or effective. Staff could identify risks for the service, but we found there was little local ownership of risks and actions.

Once risks were identified at ward level the risk department was responsible for ensuring the risk was added to the divisional risk register. Managers told us in the inspection that the risk department followed up any actions either on the review date identified or after six months.

The divisional director of nursing and senior nurses met weekly with the divisional risk management team to review severe and moderate risks and escalated these to the divisional risk committee through the patient quality and safety board. The weekly associate director of nursing reports identified all incidents and outstanding risks, and a risk reminder was sent electronically to risk owners to highlight when an action was due.
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The ward had recently undergone a cultural review where the environment and other issues regarding patient and nursing care had been discussed, however none of the issues were on the register and the review was not mentioned at all. We would have expected to see the escalation of those issues highlighted in the register also.

In our view a cultural review is a risk and senior manager in the trust need to be aware that these types of issues are occurring on their wards.

We reviewed the risk register for the medicine directorate as a whole and found the register did not always fully mitigate the risk or risks were not acted on in a timely manner. We reviewed the risk register and saw that not all risks identified had action to address the risk, target dates or persons responsible assigned to actions.

One risk for general medicine stated no controls were in place and no progress had been made, another had no action plan. A risk relating to replacement of call bells had a target date of 2029.

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There was a trust wide safety summit open for any member of staff to attend and individuals were encouraged to present at this.

The service had a system of weekly monthly and quarterly audits as part of perfect ward audits. However, this was a relatively new system across medicine and not yet fully embedded. Weekly audits were completed by ward sisters and were a mix of record checks and observational audits. These were followed by monthly matrons audit and quarterly audits by the associate directors of nursing.

These audits were reviewed every month as part of a perfect ward audit meeting attended by the divisional directors of nursing and themes identified and action plans put in place.

The service had a falls steering group which developed and monitored the falls improvement plan. This was attended by doctors, nurses and therapy staff and met every eight weeks to review progress on improvement plan.

**Information management**

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance and make decisions and improvements.

We saw evidence that services collected performance measures and data for the two wards which enabled the management to understand areas of improvement.

The data included Friends and Family data, audits and governance data which were shared with staff by managers and actioned.

Policies and procedures were readily available on the trusts intranet site and all staff told us that they had access to it.
We found that patient information was stored effectively in locked trolleys on both wards and found no patient information displayed on unattended computer screens. No patient information was left unattended in ward areas.

**Engagement**

**Leaders and staff actively and openly engaged with patients, and staff to plan and manage services. However, some staff reported they had limited opportunity to engage with the service and wider organisation to influence service development.**

Staff told us that they had constructive engagement with managers and managers. The engagement included trust newsletters and staff told us they had good feedback on the transfer of some staff to a new provider.

The service ran a 24-hour seven day a week ‘matron helpline’ for patients and relatives to speak to a matron to discuss any questions or concerns. This model had been adopted by the whole organisation after starting in medical care services.

Ward sisters had developed ways to engage with staff and to encourage staff to engage with each other on their wards.

Managers told us that from November 2019 the service was starting a forum for registered nurses. This would provide nurses an opportunity to meet executives and leaders and share ideas for service and organisational development.

However, at the time of our inspection opportunities for staff to share ideas with senior managers were limited. Some staff we spoke with told us they had limited opportunities to discuss ideas with managers and the recent away days were ‘a one off’. Therapy staff told us they did not have opportunities to get involved in audits or service improvement initiatives.

**Learning, continuous improvement and innovation**

**Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged quality improvement.**

Since our last inspection of the medicine directorate it had completed a number of quality improvement projects. For example, the service had worked to improve compliance with nutritional screening on ward. Each ward was monitored as part of the matron checklist and discussed at safety huddle.

The service had a number of continuous improvement projects such as length of stay and falls. The falls prevention group were reviewing alternatives to sleep medication to reduce falls at night such as introducing eye masks and lavender pillows.

Managers told us that all matrons had been booked onto a quality improvement training course. The service had introduced a ‘bright ideas’ email for all staff to share any ideas they had for quality improvement projects or to improve the patient experience.

Whilst we did no see quality buses’ on wards to promote improvement projects or awareness campaigns we were told that the directorate used them across both hospitals. These were cardboard information stands shaped as buses which travelled round wards to inform staff of projects and share information.