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

Well-led

Facts and data about this service

Acute hospital sites at the trust

A list of the acute hospitals at Warrington and Halton Hospitals NHS Foundation Trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warrington Hospital</td>
<td>Lovely Lane, Warrington, WA5 1QG</td>
</tr>
<tr>
<td>Halton General Hospital</td>
<td>Hospital Way, Runcorn, WA7 2DA</td>
</tr>
<tr>
<td>Cheshire and Merseyside Treatment Centre</td>
<td>Earls Way, Runcorn, WA7 2HH</td>
</tr>
</tbody>
</table>

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

Warrington and Halton Hospitals NHS Foundation Trust comprises three hospitals across two sites – one in the borough of Warrington and two co-located in Runcorn in the borough of Halton. The trust serves a population of approximately 330,000 across both boroughs and employs around 4,200 staff.

Warrington hospital is the home of the emergency and acute care services supported by intensive care, acute cardiac care unit, stroke unit and the country’s largest inpatient acute dementia ward. Maternity and paediatrics, ophthalmology, and screening services are all located here.

Halton General Hospital is where all elective work is carried out together with two integrated/intermediate care wards; the Clatterbridge chemotherapy Centre, Macmillan Delamere Centre. The Runcorn Urgent Care Centre is located at this site.

The Cheshire and Merseyside Treatment Centre is also located on the Halton General site which is a centre for orthopaedic surgery and sports medicine.

The trust reports that it has 539 beds: 431 at Warrington; 44 elective and 22 intermediate care beds at Halton and 42 trauma and orthopaedic beds at the Cheshire and Merseyside Treatment Centre.

In the year before the inspection there were 112,000 visits to the emergency department at Warrington Hospital and 30,000 to the urgent care centre at Halton General hospital. In the same period there were approximately 500,000 individual patient appointments, procedures and stays and approximately 3,000 babies were born.
Is the service well-led?

Leadership

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

- chair
- chief executive
- chief nurse
- chief operating officer
- director of finance and commercial development
- executive medical director and deputy chief executive
- five non-executive directors
- chief information officer (non-voting member)
- director of community engagement and fundraising (non-voting member)
- director of human resources and organisational development (non-voting member)
- director of strategy (non-voting member)
- deputy medical director, chief clinical information officer and director of medical education (non-voting member)

There had been a number of changes to the board make-up since our last inspection in 2017 but the board described itself as ‘strong’ and ‘stable’. The trust had an experienced chief executive who has been with the trust since 2011. The executive directors had been in post for between four years and less than six months, with four new executives since the last inspection. The non-executive directors had been in post between two and five years.

Board Members

Of the executive board members at the trust, none were Black and Minority Ethnic (BME) and 60.0% were female.

Of the non-executive board members none were BME and 33.0% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>33.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

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

The executive leadership team had a range of skills, knowledge and experience to lead and deliver the trust’s strategy. All board members spoke highly about the skills and capabilities of their colleagues on the board and the board collectively. The board was evidently very cohesive and from our inspection and observing a board meeting we saw that they demonstrated collective leadership. All the executive directors were substantive appointments and were experienced NHS senior managers, although for eight out of the ten it was their first board director role. Leadership development opportunities were available to support them in these roles and most of the executive
directors had attended national senior leadership programmes shortly before or since starting in their roles.

The performance of the executive leadership team was reviewed and monitored through an annual appraisal process to ensure they maintained the skills, knowledge and integrity to carry out their roles. The executive team had portfolios which were balanced to ensure they had capacity to deliver. Executive directors were supported by deputy directors with specific responsibilities, aligned to their portfolios, to support them in their roles.

Leaders had roles outside of the trust, specifically within the local health and social care systems. The chief executive led the board of the integrated care system, Cheshire and Merseyside Health and Care Partnership and directors were part of committees within the Cheshire and Merseyside Health and Care Partnership and the place-based systems for Warrington and Halton. In 2017-18 the trust had identified that the board needed additional capacity to support the strategic demands of the chief executive in her role at lead of the Cheshire and Merseyside Health and Care Partnership. For an 18-month period, for two and a half days a week, the executive medical director and deputy chief executive stepped up into the chief executive role, while a deputy medical director stepped up into the medical director role. The deputy medical director had remained on the board as deputy medical director, chief clinical information officer and director of medical education after the chief executive returned to her role. Leaders attended regional networking meetings with other trust, such as the North West chief executive and chair meetings and national meetings such as NHS providers meetings.

Non-executive directors and the chair had a variety of skills, knowledge, and experience and were from a range of industries and backgrounds. They had a good range of operational, finance and clinical experience from holding senior positions in banking, human resources, the fire service, psychiatry and academia. The chair reviewed the collective skills of the non-executive directors ahead of future appointments, so they had the skills and experience to address future strategic priorities. It had previously been identified that a non-executive director with experience in human resources was required which had supported the appointment of a non-executive director with experience of human resources. During the inspection period the trust was appointing a new non-executive director who was a general practitioner and chair of a clinical commissioning group as it was recognised that experience of primary care were required for future integration plans. The chair had hoped to recruit a Black and Minority Ethnic non-executive board member in the recruitment, to improve the racial diversity of the board, although a shortlisted candidate had withdrawn before interview.

Appraisal arrangements for the non–executive directors were well structured, with non-executive directors receiving annual appraisals and six-monthly reviews by the chair. The chair also held three or four one-to-one meetings with each of the non-executive directors each year. The chair’s performance was overseen by the council of governors through a formal process.

The trust had a process for ensuring that directors and non-executive directors were fit and proper, as required by 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 health and social care providers are fit and proper to carry out their roles. We reviewed the personnel files for board level directors and found the trust had carried out appropriate checks and retained all the information required by the regulation for all executive directors. The trust did not have photographic identification for two of the longer standing non-executive directors but assured us that it would have been required for disclosure and baring service checks, that this had now been obtained and that since appointment the process had been changed. We found non-
Executive directors did not have retained references on file which we had reviewed when we had previously assessed the regulation in 2017. The chair had a good understanding of the fit and proper persons process and had previously overseen the engagement of it following concerns notified to the trust.

Leaders articulated the importance of being visible across services across both hospital sites. There were many positive comments about the visibility of the chief executive, chair and the wider board. All the executive directors visited a wide range of services each month across both hospital sites. Displayed across the trust were ‘where have we been this month’ white boards which showed which wards and other areas of the hospitals each of the board members had visited in the previous month.

The trust had a monthly programme of triangulation visits with executive and non-executive directors visiting different areas of the trust. These were spread across both sites and in clinical areas and support services. Between July and December 2018 there were between two and four visits each month. Non-executive directors highlighted the importance of the visits to triangulate the evidence at the board and committees of the board. Directors gave us examples of issues which had been escalated from visits and brought back to the quality assurance committee.

In addition to their membership of the board and committees of the board non-executive directors were active in attending meetings and events at the trust and in the local community. Non-executive directors felt their role was well understood by staff at the trust.

The trust had board development sessions every other month. Sessions had covered areas which would strengthen the board’s knowledge and understanding of the operation of the trust, for example sessions had been held on clinical coding and the Mental Capacity Act. Shortly before the inspection an external governance consultancy had started a governance review and would lead a 12-month structured programme of board development.

The trust had a people strategy and delivery plan which set out its talent management and leadership development. The trust had plans in 2019-20 to develop and embed a talent management and succession planning framework to build on its current approach. The trust was also developing a leadership model which it said would articulate the knowledge, skills and behaviours required of leaders. Succession planning was well considered and there was an identified deputy for each executive director portfolio supplemented by a leadership development programme to build resilience at this level. The trust had set up a deputy’s group and planned a shadow board programme for later in 2019 to support and develop the deputy directors.

The trust offered a range of leadership development opportunities for staff, provided by the trust and externally. This included leadership programmes accredited to the Chartered Management Institute, management workshops, bespoke programmes in response to organisational need, national/regional leadership academy programmes, and place-based opportunities. In the year before our inspection 210 staff members were involved in a leadership programme.

The trust supported staff in the NHS graduate management trainee scheme and at the time of the inspection had three first year placements and employed other staff who had been on the scheme.

All board members we interviewed were well sighted on the financial position of the trust and recognised there was risk to the delivery of the current year financial plan. There was reasonable confidence in delivery albeit a significant level of financial pressure and unidentified cost improvement schemes still need to be addressed to achieve the plan.
Vision and strategy

Trust’s strategy on a page

Our Mission, Vision, Values
Aims and Objectives

Our Mission
We will be OUTSTANDING for our patients, our communities and each other

Our Vision
We will be the change we want to see in the world of health and social care

Quality
We will... Always put our patients first through high quality, safe care and an excellent patient experience

People
We will...
Be the best place to work with a diverse, engaged workforce that is fit for the future

Sustainability
We will...
Work in partnership to design and provide high quality, financially sustainable services

We will Do this by:
Continuously improving, exploring new opportunities and technology and being creative and innovative in redesigning and developing all we do.

Our Values
Working Together, Excellence, Accountable, Role Model, Embracing Change

(source: strategy 2018-2023)
The trust’s mission was to “be outstanding for our patients, our communities and each other” and its vision was to “be the change we want to see in the world of health and social care”. This was unpinned by quality, people and sustainability aims. The quality aim was to “put our patients first through high quality, safe care and an excellent patient experience”; the people aim to “be the best place to work with a diverse, engaged workforce that is fit for the future”; and the sustainability aim was to “work in partnership to design and provide high quality, financially sustainable services”. There was a strong focus on the overarching aims of quality, people and sustainability which was enduring, highly visible throughout the trust and consistently articulated by leaders. The aims were supported by a statement that the trust would achieve the aims by “continuously improving, exploring new opportunities and technology and being creative and innovative in redesigning and developing all we do.” The trust had five values which were well established, these were: working together, excellence; accountable; role model; and embracing change.

In 2017-2018 the trust had refreshed its five-year strategy and many of the enabling strategies. In May 2018 the board approved the strategic objectives, outcomes and measures, which was launched in July 2018, and at the time of our inspection the trust published a strategy document titled “Our Strategy 2018-23”. The strategy was following a wide range of involvement, engagement and consultation with the clinical and senior management team, governors, patients, staff, partner organisations and other stakeholders.

The trust had three strategic objectives under each of the three aims (quality, people, sustainability).

Quality

- Patient safety – we are committed to developing and enhancing our patients’ safety through a learning culture where quality and safety is everyone’s top priority.
- Patient experience – by focusing on patient experience we want to place the quality of patient experience at the heart of all we do, where “seeing the person in the patient” is the norm.
- Clinical effectiveness – ensuring practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients.

People

- Attract and retain a diverse workforce aligned to our culture and values to ensure that we have the staff with the skills, attitude and behaviours to meet the needs of our population providing excellent and safe care.
- Create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff safety and experience.
- Develop a collaborative, compassionate and include culture of collective leadership at all levels and organisational learning.

Sustainability

- Play a central role in our healthcare economies to support integrated place-based care.
- Work with other acute care providers to ensure that those services which need to be provided in an acute environment are the best they can be and are clinically and financially sustainable.
• Provide our services in an estate that is fit for purpose, supported by technology, and aligned to the needs of our developing populations.

The board had put mechanisms in place to track progress on the delivery of the strategy. The trust had developed a range of outcome measures, key performance indicators and monitoring arrangements for the strategic objectives, with measures mapped to board committees for scrutiny and review. The trust had a strategy development and delivery committee which monitored the progress of individual projects and exception reports were provided to the relevant board sub-committees. The trust board received a dashboard setting out the progress against each of the agreed outcome measures and key performance indicators. This was positive although it is at an early stage of implementation.

The trust reported progress against achieving the aims of the strategy in the first year including: opening of frailty assessment unit, gynaecology assessment unit and a combined cardiology ward; £3 million investment in ward-based nursing, the planned redevelopment of the Halton site being recognised as top priority for capital investment in Cheshire and Merseyside and the inclusion of a new hospital for Warrington in the council’s local plan.

One of the longer-term strategic ambitions included a Halton Healthy New Town, an innovative hospital and wellbeing campus and a new hospital in Warrington. Ahead of the plans for new hospitals being realised the trust planned to optimise the use of the Cheshire and Merseyside Treatment Centre on the Halton site.

The trust’s strategy was supported by a clinical strategy for 2018-23 which was approved by the board in January 2019. The clinical strategy was developed bottom-up with the operational teams and covered all the trust’s clinical specialities and was aligned to the regional and local health and social care agenda. The clinical strategy set out the trust’s position on regional service reviews and had a specific vision for each of the 33 clinical specialities across the trust. Specialty specific strategic priorities were included in the yearly business plans for the relevant clinical business unit and delivery against those objectives was monitored through the quality, people, sustainability meetings.

The trust had a suite of enabling strategies to support the delivery of its strategy. These included strategies covering patient experience; nursing and midwifery; allied health professionals; frailty; the quality academy; children and young people; end of life; safeguarding; dementia; equality, diversity and inclusion; freedom to speak up; digital; finance; estates and facilities; and patient and public participation and involvement. Clinical business units’ ‘plans on a page’ had plans and priorities for services but the trust did not have targeted delivery plans for all the enabling strategies and they were not clearly aligned with the clinical strategy. The plan to achieve financial sustainability was not well developed and further work was planned by the board to address this.

The trust had a quality strategy for 2018-2023 which focussed on how the trust would deliver its three quality strategic objectives including the priorities for 2018-19 and the trust’s approach to quality improvement and engagement.

The most recent dementia strategy the trust had was for 2017-18 although the trust told us it was currently developing an updated strategy. The trust told us it did not currently have a learning disability strategy, but it was in development. The trust did not have a mental health strategy, although had strong links with the local NHS mental health trust and had a programme of work to improve services for patients with mental health needs attending the emergency department. The trust had recently developed a safeguarding strategy which had been approved and was being produced at the time of the inspection.
Sustainability and transformation plans are part of a national programme where the NHS, local authorities and social care form partnerships to improve health, the quality of social care and efficiency of services in a geographical ‘footprint’. The trust was part of the integrated care system, the Cheshire and Merseyside Health and Care Partnership. The trust was active within the system and the chief executive was the lead of the system’s board. As the two hospital sites were in different boroughs the trust was part of two place-based systems: Warrington Together and One Halton. The trust was a lead partner in both place-based systems which the trust reported was moving at a faster pace that the integrated care system.

The trust had plans for vertical and horizontal integration within the regional and place-based systems. The trust had ambitions to be the ‘eastern hub’ within the Cheshire and Merseyside Health and Care Partnership for the provision of cancer services; wanted to retain and build paediatric services; wanted to play a key role in the regional delivery of clinical support services and was committed to collaboration with other providers of elective care to improve services.

The trust was developing its relationship with the local NHS community provider with plans to become an integrated care provider in the future. This was realised as opportunity for both organisations to achieve long term financial sustainability and integrated acute and community healthcare for the local population. The trust had taken initial steps including having recently signed a memorandum of understanding and holding executive-to-executive meetings. During the inspection period the trusts had held board-to-board meetings and future meetings were scheduled. The director of human resources already was in post for both organisations.

The trust was also working with a neighbouring NHS acute trust within the Cheshire and Merseyside Health and Care Partnership to share some back-office functions, such as payroll, and had developed a joint stroke pathway with an initial acute thrombolysis service at the neighbouring trust’s hospital. The trust had further plans to collaborate with the provision of services supported by an acute sustainability programme with the neighbouring trust.

The trust had an annual operation plan which set out the activity, quality, workforce and financial planning for the coming year. An operational plan is a mandatory requirement to be submitted to NHS Improvement every year. The operational plan was well connected to the overall trust strategy. Each of the clinical business units were able to articulate the process by which annual priorities were agreed in the context of the trust’s strategic direction. Clinical business units’ business plans were set out on a standardised ‘plan on a page’ template which set out finance, activity, priorities and plans.

The board recognised an underlying deficit of approximately £20million. However, the key drivers of the deficit were not coherently explained. This was a potential weakness in developing a financial sustainability plan if the reasons for the deficit were not well understood by the board.

Pharmacy had a clear strategy and vision. Medicines optimisation priorities were set in the hospital pharmacy transformation plan and were regularly monitored and escalated appropriately. The chief pharmacist was directly involved in local systems and the Cheshire and Merseyside Health and Care Partnership to make sure wider health economy plans included the trust.

Culture

In all the services we inspected we found a positive culture, where staff felt supported, respected and valued. Leaders told us, and we found, staff were friendly and warm. Staff were positive about their leaders and were proud and happy to work at the trust. Staff at both sites felt equally part of
the trust. This was evidenced through improved performance on the staff survey and growing success in recruiting to hard to fill clinical roles.

We observed at the trust board meeting and in interviews with leaders that they were respectful and supportive. Leaders were enthusiastic and proud of the staff at the trust. Board members were clear that there was a strong focus on openness and transparency and this was the culture they were working hard to embed within the trust.

Staff we spoke with across the trust were patient centred and prioritised the needs and experience of the patients. During the winter period in 2018-19 89.6% of staff had a flu vaccination which was the second highest rate for an acute trust in England. While leaders understood the needs of the patient, on our inspection of the leadership this was often articulated to us in terms of ‘quality’ of care, rather than the needs and experience of patients using the service.

The board and quality assurance committees had patient stories at the start of every meeting. A patient story is the experience of a service user or their carers told from their perspective giving staff the opportunity to understand their experience of the care they have received. During the board meeting we attended, the patient’s family members presented the patient story with the staff who had been involved in the treatment.

**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.

Of the 10 key themes from the survey, quality of appraisals scored below the average benchmark group and the remaining nine themes were similar or higher.
The trust’s 2018 scores for the following themes were significantly higher (better) when compared to the 2017 survey:

- Safety culture
- Staff engagement

(Source: NHS Staff Survey 2018)

Friends and Family test

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

The trust scored about the same as the England average for recommending the trust as a place to receive care from February 2018 to January 2019.

(Source: Friends and Family Test)

The trust reviewed the inpatient and day cases and emergency department and urgent care centre friends and family test data at the board as part of the integrated performance report. Due to a decrease in the scores in the emergency department the board had commissioned a deep dive and an action plan was in progress to improve the response rate and recommendation rate.

Sickness absence rates

The trust’s sickness absence levels from November 2017 to October 2018 were higher than the England average.
Staff we spoke to across the trust were open and honest, staff were encouraged to report incidents, which had been made easier with changes to the incident reporting systems. Senior leaders were candid about issues and areas for improvement. Board papers reflected that items discussed at the private board meeting were because of privacy or commercial sensitivity.

The trust had 18 whistleblowers between 1 April 2017 and 31 December 2018. The trust had identified the themes as: behaviour and relationships (seven); patients’ safety (five); staff dignity (five); and staff safety (one). The trust had taken a range of actions in relation to whistleblowers including customer care training, mediation, triangulation of staff survey data, visits and bringing forward ward accreditation.

Freedom to speak up guardians work with trust leadership teams to create a culture where staff can speak up to protect patient safety. The role of the freedom to speak up guardians had been created because of recommendations from Sir Robert Francis in February 2015. The trust had a freedom to speak up strategy which set out the vision for the freedom to speak up guardian role. The trust’s freedom to speak up guardian was the deputy director of finance and had been in post since May 2017. The guardian was supported by three freedom to speak up champions who worked in different clinical and non-clinical roles. The guardian reported bi-annually to board and met with the chair, chief executive and responsible non-executive director every three months.

Since starting in post, the guardian had aimed to increase visibility of the role through posters and attendance at training and other events. The trust reported that there was an increased awareness of the guardian and how to access the service. In 2017-18 there had been 10 approaches to the guardian which had increased to 22 in 2018-19.
Union leaders reported a good relationship between the trust staff and union representatives. Executive directors attended the joint negotiating consultative committee with the representatives of the unions. The chief executive attended the committee once a year.

The trust had processes for ensuring that the trust met the requirements of the duty of candour. The duty of candour is a requirement of providers to be open and honest with service users and other ‘relevant persons’ (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. The trust had established patient/family liaison role for senior clinicians as part of the serious incident procedure to support and deliver the duty of candour.

Compliance was monitored using the electronic incident reporting system and daily monitoring was undertaken by the clinical governance department. At the weekly executive meeting of harm, chaired by the chief nurse, compliance and the contact with patients and families was overseen and discussed. Board members and all senior managers received a weekly report which included compliance with the duty of candour, which was also covered on the trust’s integrated performance report. A report of serious incidents, including the duty of candour, was provided to the monthly patient safety and clinical effectiveness committee. During the inspection we reviewed a sample of 11 serious incidents which met the threshold of the duty of candour. In each case the trust had contacted the person or family member within 10 days to notify them of the incident, apologise and inform them of the investigation which would take place. The trust had then shared a copy of the investigation report and apologised again once it was complete.

The trust had a target for 85% of staff to receive an annual appraisal. In 2018-19 the trust met its target with a total of 86% of staff receiving an annual appraisal. Of this total 86.1% of medical staff received an annual appraisal, 83.4% of nursing and midwifery staff received an appraisal and 88.4% of other staff received an appraisal.

The trust had plans to develop the appraisal process in 2019 to refresh the approach to focus on behaviours in addition to objectives. The trust planned to refresh the trust’s behaviours outlined within the appraisal documentation, through engagement with staff from across the organisation. The trust planned to be able to use the refreshed process to identify, develop and retain talent.

One of the trust’s people pledges, within the people strategy, was to help staff to be healthy and support them if they were or became unwell. The trust had four workstreams and a number of deliverables to achieve the pledge relating to the occupational health service, mental health services, physiotherapy and health promotion. The trust’s health and wellbeing team offered a full occupational health service in addition to hosting events and offering services such as free counselling, physiotherapy, a weekly fruit and veg stall, discounted gym memberships and exercise classes before and after work. The trust had embraced the role of mental health first aiders and had 100 across the trust with plans for more staff to be trained. The trust had a programme of monthly campaigns of health promotion and education. For example, in April 2019 the trust had a “know your heart numbers” event which offered a range of screening tests such as blood pressure, blood sugar and atrial fibrillation testing, as well as immediate access to a consultant cardiologist where appropriate. During the two-day event 220 staff members were screened.

The trust awarded employee and team of the month and had an annual awards ceremony at a local hotel to thank staff and celebrate successes. Teams and individuals were given awards in nine categories shortlisted by staff. Staff were also given badges to wear on their lanyards if they demonstrated one of the trust’s values.
Staff Diversity

The trust provided the following breakdowns of staff groups by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Qualified nursing and health visiting staff (%)</th>
<th>Qualified nursing midwifery staff (%)</th>
<th>Qualified allied health professionals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>50.0%</td>
<td>88.9%</td>
<td>98.4%</td>
<td>94.4%</td>
</tr>
<tr>
<td>BME – British</td>
<td>41.2%</td>
<td>7.5%</td>
<td>N/A</td>
<td>4.4%</td>
</tr>
<tr>
<td>BME – Non-British</td>
<td>8.1%</td>
<td>2.7%</td>
<td>0.8%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Unknown / Not stated</td>
<td>0.7%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

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

Workforce race equality standard

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

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

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

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts’ circumstances.
As of May 2018, two of the ESR staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

1a. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles (1.5% of BME staff compared to 5.1% of White staff). The score had remained similar to the previous year, 2017.

2. In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (13.7% of BME staff compared to 22.0% of White staff). The score had remained similar 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:

5. 29.9% of BME staff experienced harassment, bullying or abuse from patients, relatives and the public in the past year (2018 NHS staff survey) which was significantly higher when compared to 21.2% of White staff. The score had remained similar when compared to the previous year, 2017.

7. 76.1% 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
90.7% of White staff. The score had remained similar when compared to the previous year, 2017.

8. 12.3% 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 4.5% of White staff. The score had remained similar when compared to the previous year, 2017.

9. There were no BME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

In February 2019 the trust completed the equality delivery system (ESD2) self-assessment and assessed itself as achieving 15 out of the 18 questions and excelling in two questions: “when at work, staff are free from abuse, harassment, bullying and violence from any source” and “flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives”. The trust said it was working towards one question: “staff report positive experiences of their membership of the workforce”.

In March 2019 the board approved an equality and diversity and inclusion strategy for 2019-2022, this replaced the previous equality strategy for 2013-17. The strategy had four patient pledges and four staff pledges which were supported by a series of priorities. The strategy was developed through wide public engagement with organisations, individuals and advocates representing eight of the nine protected characteristics defined in the Equalities Act 2010. The trust said the strategy reflected the actions from the workforce race equality standard and equality delivery system results and action plans.

The trust had equality and diversity champions and was in the process of appointing learning disability champions. Staff received training on equality and diversity and unconscious bias as part of mandatory training and other development programmes. As part of the new strategy the trust was reviewing the awareness, training and development available for all staff.

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed worse than expected for two indicators (clinical supervision and educational supervision) and the same as expected for the remaining 11 indicators.

(Source: General Medical Council National Training Scheme Survey)

Due to the concerns highlighted in the 2018 survey and the Health Education England annual assessment visit, the trust was placed in special measures and under enhanced monitoring by Health Education England. The trust had been on enhanced monitoring by Health Education England for several years. Following a further visit in November 2018 the trust sent the trust a series of actions it must take to improve against Health Education England standards. The trust told us that some of the challenges had been in areas where it was hard to fill consultant posts. The trust was required to submit the action plan by the end of April 2019. The issue had been added to the board assurance framework and escalated to the strategic people committee and the board. There were further actions identified through developing a junior doctors experience group and a junior doctors’ forum, both chaired by the director of medical education. The trust had reduced its overall risk score (scored by Health Education England) and hoped to improve its General Medical Council survey which was out at the time of our inspection.
Pharmacy and medicines staff had annual appraisals and had regular personal development reviews. Medicines optimisation issues were raised in safety huddles to make sure important urgent risks were shared in a timely way. Clear lines of accountability were in place to promote safe medicines optimisation within the trust board governance arrangements.

**Governance**

Since the last inspection the trust had carried out a whole system governance review and implemented a new integrated governance model, supported by changes to risk management, incident reports and investment in the governance team and board secretariat.

The board met every other month and received reports from six committees: audit committee; charitable funds committee; finance and sustainability committee; nomination and remuneration committee; quality assurance committee; strategic people committee. The trust also received reports from the trust’s operational board.

The trust had a formal committee structure beneath the committees of the board, with a range of committees and groups reporting to the relevant board committee. Committees of the board had clear terms or reference and an annual cycle of business. Committees of the board were each chaired by a different non-executive director with another non-executive director a member. All non-executive directors were members of the audit committee which provided good oversight of the trust’s overall system of internal control and cross fertilisation across the other board committees.

The trust had processes to review the effectiveness of committees of the board with an annual review led by the head of corporate affairs and the chair. This involved a survey of all members of the committee. The chairing of committees and the board was informally reviewed and the trust gave us examples of improvements to the functioning of committees following feedback to chairs.

The quality assurance committee had the greatest number of committees within its portfolio with 40 committees and groups sitting beneath it in the meeting structure including the patient safety and effectiveness sub-committee, patient experience sub-committee, adult and children safeguarding committee, health and safety and wellbeing sub-committee, complaints quality assurance group and risk review group. The chair of the committee told us the committee had evolved since the last inspection from a focus on operational business to assurance, which was reflected in a change of the committee’s name from quality committee to quality assurance committee.

There was a standardised approach for each of the board committees to report to the board. The trust used a system of high-level briefings to escalate information through the committee structure. High level briefings from meetings set out items where assurance could be provided to the receiving committee and items to escalate where there were active or potential risks and the action taken. The board received reports from the reporting committees setting out issues and the recommendation and assurance for each issue. Directors were able to articulate the nature of challenge and debate and outlined how they deployed a “deep dive” approach on areas of concern with representatives of the clinical business units attending the board committees.

We reviewed a sample of recent board meeting papers and observed a board meeting during the inspection period and found that the agendas were appropriately balanced between quality, finance, performance and strategy. Issues were escalated, and assurance sought from the committees of the board. All non-executive directors and the chief executive provided scrutiny,
challenge and support to directors, holding them to account for their areas of responsibility. All board members were respectful, and conversations appeared to be open and authentic.

While board and committee papers were sometimes long members were generally happy with the level of detail and length. We were told that the board development programme, over the next year, with an external governance consultant, would review the board papers to ensure only the necessary information was included and the quality of executive summaries.

There was clarity on the coverage of executive director portfolios. The portfolios except for the strategic portfolio had remained stable. The recent change to portfolios in respect of the ownership and delivery of the efficiency programme was still being fully embedded.

Since the last inspection the trust had changed its divisional structure creating eight clinical business units each with a triumvirate of a clinical director, lead nurse and operations manager. Since the clinical business units had been created, they had replaced the divisional structure. Leaders and staff were positive about the clinical business unit structure which they said supported strong clinical leadership due to the alignment of specialties and services and had provided good visibility of clinical leadership at speciality level. This had enhanced clinical engagement. All clinical director roles were filled, supplemented by some associate roles. There was a business partner model for both finance and human resources in supporting the business units. Clinical business units and the specialties within the units had governance meetings and escalated issues through the trust’s committee structure.

The trust’s clinical business units

![Diagram of clinical business units]

- Executive Team
  - Corporate Support Services
    - Digestive Diseases & Anaesthetics
    - Musculoskeletal Care
    - Urgent and Emergency Care
    - Outpatients and Diagnostics
    - Women’s and Children’s Health
    - Specialist Surgery
    - Integrated Medicine & Community
    - Medical Care
In addition to the formal committee structure there were regular meetings with leaders across the trust. The chief executive held weekly meetings with the executive directors and the chair held informal meetings with the non-executive directors before board meetings. The chief executive and chair also had fortnightly one-to-one meetings. The executive medical director, chief nurse and chief operating officer met weekly with the respective leaders of each of the clinical business units. The medical director also held a fortnightly medical cabinet with clinical directors and other medical leaders.

The medicines governance committee reported to the patient safety and clinical effectiveness committee which reported to the quality assurance committee which reported to the board to provide assurance on the safe and cost-effective use of medicines across the trust. The trust hospital pharmacy transformation plan was overseen by a multidisciplinary management team with the chief pharmacist as project lead; recent updates indicated appropriate oversight of medicines optimisation metrics and targets.

In May 2018 the trust had set up a daily safety huddle and morning safety brief bringing representatives from all wards and departments for a 15-minute huddle to discuss safety issues, hot topic of the week, bright spots (positive feedback) and any ‘halt' moments. This was followed by a summary email to all staff within an hour of the briefing. We observed a safety huddle during the inspection and saw that staff were open and supportive in sharing issues and acting to resolve them.

Since the last inspection the trust had strengthened its procedures for reviewing clinical policies. The trust had set up a clinical policy group to review and consolidate clinical policies and ensure they were in date and risk assessed. Policies were all uploaded to a central hub accessible by staff. The trust had also revised its process for assessing and auditing against National Institute for Health and Care Excellence guidance. The trust's governance team had oversight of the process with actions from non-compliant audits being tracked by clinical business units.

Cost improvement planning had recently been devolved to the clinical business units along with transformational and programme management resource. The trust reported they were making good use of benchmarking tools in formulating the efficiency programme including model hospital and “getting it right first time” (GIRFT). These changes were at an early stage of implementation and at the time of the inspection in May 2019 there remained a significant gap in the current year plan. This coupled with a historic reliance on non-recurrent schemes indicated that this aspect of planning and delivery needed to be strengthened.

There was a process for budget setting although budgets were described as challenging due to a significant level of unfunded cost pressures and the gap in the current year cost improvement programme. It was evident that these matters were kept under regular review by the finance committee and reporting to the board.

The business case process was well understood by the business units with a standardised template under the “right way to yes” mantra, developed by the director of finance. There was a focus on ensuring business cases were aligned to trust strategy.

Clear reporting lines of communication were in place between the pharmacy, trust management and the board. Pharmacy staff inputted into medicines management training for internal staff. Governance systems for managing patient group directions were in place but full trust wide oversight of staff authorised to administer medicines under the patient group directions was not in place; the chief pharmacist recognised this issue and had plans to develop a digital solution to improve safety.
Management of risk, issues and performance

The trust had a clear structure and processes for reporting, monitoring and managing performance from ward to board. The trust had a performance assurance framework which set out the trust’s performance systems and structures. The system had been revised following an annual review of the framework at the time of our inspection.

Clinical business units, wards and departments were responsible for monitoring performance locally. There was a monthly key performance indicator sub-committee with the business units led by the chief operating officer which was focused on the delivery of key patient access targets. The finance director also chaired a financial scrutiny group with the business units, reporting through to the board level finance committee. In the revised structure, clinical business units attended monthly quality, performance, sustainability meetings twice a year, on a rolling basis, which were attended by the executive team. Clinical business units had full service review and were held to account on their performance and progress against strategic work programmes. This replaced the previous structure with a monthly operations board where the executive team met with the clinical business units and review at the weekly executive meeting. Both structures had links to the board committees and a review of trust wide performance at the board. The trust planned to explore using an earned autonomy framework, where clinical business units were given autonomy over the decisions if they demonstrated good performance.

The trust had performed well against nationally set access targets such as starting cancer treatment and referral to treatment, although was not meeting the target for waiting times in the emergency department. All board members articulated performance in the emergency department as a major area of challenge.

The trust had a systemic programme of clinical and internal audit to monitor quality and operational and financial processes. The trust had an annual internal audit programme agreed with the internal auditors and approved by the audit committee. This included routine annual audits of processes and audits aligned to risks, concerns and strategic objectives. Leaders reflected that the focus of the programme was on areas where there were issues or risks. The audit programme, outcomes of audit and action plans were reviewed by the audit committee which reported to the board. While the audit programme was agreed for the year in advance directors told us that audits would be added when assurance was required during the year. The trust planned to strengthen arrangements for tracking the implementation of internal audit recommendations. The audit committee were establishing a process for all limited assurance internal audit reports whereby the relevant senior manager would attend the audit committee to discuss the action plan. These changes were positive in tightening assurance.

The internal auditor gave an annual report of opinion for the year. In 2018-19 the overall opinion was of moderate assurance, based on three substantial, five moderate and three limited assurance opinions within the year. The auditors reported that it had undertaken follow up reviewed and that the trust had continued to make progress against the recommendations. The limited assurance opinions were on the review of servers, non-clinical temporary staff and the overtime review.

The trust commissioned external auditors for a statutory audit of financial statements and value for money arrangements. Progress of the external audit was monitored through the audit committee.

The trust had an annual clinical audit programme for the year which incorporated national audits, trustwide audits, local audits and audits of compliance with National Institute for Health and Care
Excellence guidance. Progress against the audit programme was monitored by the patient safety and clinical effectiveness sub-committee which reported to the quality assurance committee.

The trust had made improvements to the management of risks since the last inspection. Following the last inspection, the trust reviewed and revised its risk management processes and structures and invested in an electronic risk and incident management system which is widely used across the NHS. The trust introduced an organisational wide training programme on risk management and risk assessment to support the new processes.

Risks were recorded on a ward, specialty or team risk register, clinical business unit risk register, corporate risk register or on the board assurance framework. Risks were scored and controls and assurance, and actions recorded. The likelihood and consequence of each risk was scored out of five, giving an overall score out of 25. Risks scoring between one and eight were added to the ward, specialty or team risk register. Risks scoring from 10 and above were recorded on the clinical business unit’s risk register. Trust wide risks were recorded on the corporate risk register and strategic risks impacting on the ability of the trust to deliver its strategy were recorded on the board assurance framework.

The trust held a monthly risk review group which reviewed the board assurance framework and the clinical business unit’s risks on a rolling programme. The risk review group or the responsible executive director for a risk decided if a risk was a strategic risk which needed to be added to the board assurance framework. The board assurance framework had detailed information about the assurance details and gaps, initial, current and target risks scores and the actions taken to mitigate and reduce the risk.

The board approved changes to the board assurance framework at every meeting. This was supported by a paper setting out the actions and changes to strategic risks since the last meeting. The audit committee and quality assurance committee also carried out deep dives of strategic risks on the board assurance framework to ensure they were being managed appropriately and reported this to the board in the high-level briefings.

The trust had streamlined its board assurance framework and there was good evidence this was dynamic. The trust reported that the number of strategic risks on the board assurance framework had significantly reduced in the previous year to reflect that actions from the last CQC inspection had been actioned and embedded, so the risk had been deescalated. In September 2018 there were 26 risks on the board assurance framework, which had reduced to 19 in January 2019 and was at 15 at the time of the inspection. The trust carried out an annual internal audit of the board assurance framework process and in the latest review the outcome was that the process was meeting all standards.

As part of the forthcoming board development programme, facilitated by an external governance consultancy the board planned to further evolve its risk management processes, particularly regarding risk appetite and alignment to the delivery of the trust strategy. The risk management strategy was under review at the time of the inspection with a plan to be presented to the board in July 2019.

We found that leaders had a strong and shared understanding of the strategic risks facing the trust. While senior leaders had a strong understanding of the risks, and specifically those they were responsible for, leaders lacked clarity in articulating the risk management processes.
### Board assurance framework

At the time of our provider information request (January 2019), the trust’s board assurance framework had 19 strategic risks.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>115</td>
<td>Failure to provide adequate staffing levels in some specialties and wards, caused by inability to fill vacancies, as well as staff sickness. This results in pressure on ward staff, potential impact on patient care and impact on trust access and financial targets.</td>
<td>20</td>
<td>12</td>
</tr>
</tbody>
</table>
| 134 | Financial Sustainability  
  a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken.  
  b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the trust. There is a risk that current and future loans cannot be repaid and this puts into question if the trust is a going concern. | 20                   | 10                  |
<p>| 117 | Failure to successfully counter the regulatory and contractual consequences, caused by the suspension of spinal services in September 2017, resulting in significant reputational damage. | 16                   | 8                   |
| 125 | Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. | 16                   | 4                   |
| 135 | Failure to provide adequate and timely IMT system implementations and systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial &amp; performance targets. | 16                   | 10                  |
| 138 | Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. Resulted in a financial impact, external reputation damage and poor management decision making due to lack of quality data. | 16                   | 8                   |
| 186 | Failure to provide HCAI surveillance data and take timely action. Caused by lack of IT software. Resulting in a risk of outbreaks of healthcare associated infection. | 16 | 8 |
| 224 | Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to trust reputation, financial impact and below expected patient experience. | 16 | 8 |
| 701 | Failure to provide continuity of services caused by the scheduled March 2019 Brexit resulting in difficulties in procurement of goods and services, workforce and the associated risk of the increase in cost of supplies. | 16 | 4 |
| 145 | Influence within Cheshire &amp; Merseyside a) Failure to deliver strategic vision, including two new hospitals and vertical and horizontal collaboration, and influence sufficiently within the Cheshire &amp; Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services which may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b) Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. | 15 | 8 |
| 695 | Failure to meet NHS cervical screening programme standards for failsafe of backlog of cervical cancer patients screening reviews. Caused by lack of an implementation of a policy for undertaking the invasive cancer audit and disclosure. NHSCSP guidance issued in 2013 resulting in non-compliance with cervical screening specification 2018/2019 and NHSCSP guidance. (Strategic objective one) | 15 | 6 |
| 88  | Failure to implement the requisite GDPR (General Data Protection Regulation) policies, procedures and processes caused by increasing competing priorities due to an outdated IM&amp;T workforce plan resulting in areas of Data Protection non-compliance. | 12 | 6 |
| 120 | Failure to identify and manage patients’ risk of sustaining a fall, caused by inadequate risk assessment and | 12 | 12 |</p>
<table>
<thead>
<tr>
<th></th>
<th>Implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient’s experience, may prolong their length of stay, and give rise to complaints and claims against the trust.</th>
</tr>
</thead>
<tbody>
<tr>
<td>122</td>
<td>Failure to provide assurance regarding the trust’s safeguarding agenda being implemented across the trust, caused by gaps highlighted during external review may result in having an impact on patient safety and cause the trust to breach regulations.</td>
</tr>
<tr>
<td>123</td>
<td>Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care, with patient safety, operational, financial and reputational consequences.</td>
</tr>
<tr>
<td>143</td>
<td>Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and trust reputation.</td>
</tr>
<tr>
<td>241</td>
<td>Failure to retain medical trainee doctors caused by lack of recruitment resulting in risk to reputation and service provision.</td>
</tr>
<tr>
<td>414</td>
<td>Failure to meet NHS cervical screening programme standards for failsafe of backlog of cervical cancer patients screening reviews. Caused by lack of an implementation of a policy for undertaking the invasive cancer audit and disclosure. NHSCSP guidance issued in 2013 resulting in non-compliance with cervical screening specification 2018/2019 and NHSCSP guidance. (Strategic objective three)</td>
</tr>
<tr>
<td>133</td>
<td>Failure to successfully engage the workforce, caused by the potential for an adverse working culture which resulted in the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the trust’s strategic objectives</td>
</tr>
</tbody>
</table>

(Source: Trust Board Assurance Framework)

Staffing was identified as a key risk by all leaders and the trust had a range of measures to mitigate and reduce the risk. The trust had invested £3million in staffing and was diversifying its staffing models, for example by using roles such as physician associates and advanced nurse
practitioners. The trust was focussing on attracting staff to hard to fill vacancies and on staff retention. The trust had systems to monitor and move staffing shortfalls and move staff where appropriate. When staff were moved the trust aimed to move staff within clinical business units. Staffing at ward level was reported to the board and publicly in the safe staffing report.

In January 2019 CQC carried out an unannounced inspection of the emergency department at Warrington Hospital. This was part of a national programme of inspections of emergency departments over the winter period and was published at the time of this inspection. The inspection had identified concerns about patients being unable to flow through the hospital effectively, as well as being cared for in inappropriate areas of the hospital. We saw evidence that the trust had escalated the issues raised in the report to the quality assurance committee and the board and had created an action place to address the issues identified during the inspection.

The trust had proactively commissioned external clinical reviews of a number of clinical services where risks or concerns had been raised through governance processes. Leaders told us they had a low threshold for seeking an external or peer review to provide assurance. Following a number of serious Incidents in a short timeframe, the trust voluntarily suspended its spinal services in October 2017 and, along with commissioning colleagues, invited the Royal College of Surgeons to undertake a review in November 2017. The Royal College of Surgeons shared the report with the trust in February 2018 and made a number of recommendations about the future configuration of the service. These recommendations were being fed into a systemwide review of the configuration of spinal services across Cheshire and Merseyside. At the time of the inspection spinal services remained indefinitely suspended and all patients had been handed over clinically to other providers. Regular updates were provided to directly to the board, as well as through the committee structure.

In 2018 the trust commissioned reviews of the laparoscopic cholecystectomy practise of a consultant surgeon, the mortuary and a number of stillbirths within the trust. The report of the laparoscopic cholecystectomy practise led to actions which were escalated to the quality assurance committee and the mortuary and stillbirth reports gave assurance about the incident reporting investigation and actions.

The trust also reviewed external reports to identify learning for the trust. The trust had reviewed the findings from independent review of Gosport Hospital and benchmarked itself against the findings. The trust found that it met most requirements.

The trust governance team provided a weekly report to the board with an update on incidents, serious incidents, complaints, claims and inquests so board members could see new incidents and issues.

Since the last inspection the trust had started a monthly triangulation meeting which included the executive medical director, chief nurse and director of governance and quality which reviewed information about incidents, claims and complaints in addition to information about staff such as performance issues, late appraisals or any investigations by professional bodies. The trust gave an example of an issue identified through concerns raised about a clinician.

In 2018 the trust developed and launched a ward accreditation programme, “ACE accreditation for excellence”. At the time of our inspection every ward across the trust had been inspected. Accreditation visits were carried out by a small team of senior nurses led by the associate chief nurse and attended by the improvement lead. The involved a desktop review and a visit to the ward observing care, reviewing records, talking to patients and staff, inspecting the environment, understanding team communication and discussing the ward’s quality improvement journey.
Wards were awarded gold (excellent), silver (very good), bronze (good), white (not achieving minimum standards in at least one area) or were 'flagged' (serious concerns). All wards in 2018 had achieved either silver or bronze status. The trust had plans to expand the accreditation programme in 2019 to other clinical areas such as outpatient areas and theatres. The trust was also looking to develop a ward round accreditation programme to review and accredit medical ward rounds.

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£233.3m</td>
<td>£234.7m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£4.9m)</td>
<td>(£14.7m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£241.6m</td>
<td>£249.4m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£18.6m)</td>
<td>(£3.8m)</td>
</tr>
</tbody>
</table>

The trust did not provide their projections for the next financial year (2019/20).

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

The trust had a planned turnover of approximately £260m in 2019-20. The trust recognised an underlying deficit of some £20m and had delivered a deficit of this magnitude in the last two years. For 2019-20 the trust had agreed a financial control total with NHS Improvement and would be eligible for £20m of system sustainability funding and had set a financial plan to break even in the current year.

The plan to break even in 2019-20 was predicated on the delivery of a cost improvement programme of £7.5m (3%) plus the resolution of £5m of cost pressures. At the time of the inspection in May 2019 these requirements had not been fully addressed.

There was significant risk to the delivery of the current financial plan due to unidentified cost improvement schemes and a high level of unfunded cost pressure. Whilst the board were sighted on the level of risk to the financial plan, the board to understand the action required to close this gap and whether this was attainable within the year. This work needed to move at pace. Due to the challenging underlying position the trust was in receipt of revenue support loans of £57m to provide adequate cash flow.

Further work was required to deliver a medium-term financial sustainability plan, and this was work in progress at the time of the inspection. The trust was previously under legal undertakings on the grounds of finance but exited these in 2018. It remained under regular review from NHSI.

All board members articulated the importance of finance and their endeavour to deliver on the financial plan, but the overriding priority was patient quality and safety. Leaders emphasised that quality of care and patient safety would always be a priority over finance and that financial pressures would never compromise care. Leaders said they had worked with staff to ensure that this message was clear for frontline staff. Despite the challenging financial position, the board has increased investment in improving patient quality, for example with additional clinical workforce. Senior leaders spoke very positively about the supportive and collaborative approach of the finance team in pursuing business cases or proposals.
There were positive comments from the non-executive directors and senior managers about the contribution the finance team make to the wider trust agenda. The deputy director of finance had taken on the role of the freedom to speak up guardian. There were opportunities for finance training provided by the finance team and through e-learning tools covering relevant topics.

The trust had a quality impact assessment process for the cost improvement programme or other service developments. A three-stage process was agreed in January 2019 following a review of the processes. The first stage was for two of the three clinical business unit’s triumvirate leads or the corporate area lead to sign off the quality impact assessment. The second stage was a preliminary review by the deputy chief nurse and finally clinical business unit or clinical schemes were reviewed and approved by the chief nurse and executive medical director and corporate area schemes were reviewed and approved by the chief nurse or the executive medical director and an independent executive director. Schemes were assessed against their qualitative impact on patients and staff and the impact on local and national targets.

The trust had systems and processes to monitor and promote infection prevention and control. The director for infection prevention and control was the chief nurse who was supported by a lead nurse for infection prevention and control. The trust had an infection control committee which reported through the committee structure to the quality assurance committee with a quarterly report and an annual report to the board. The trust had meetings to escalate infection prevention and control issues and champions for areas such as aseptic non-touch technique.

Audits of systems and key risks for medicines were managed including audits of medicines reconciliation, controlled drugs, missed doses and safe and secure handling of medicines. Identifying, reporting and investigation of missed doses for critical medicines was identified as inconsistent across the trust.

Pharmacy risk register was regularly reviewed, and risks were escalated to board level through governance structures. Pharmacist support on critical care was not at the level recommended by the Faculty for Intensive Care Medicine. The trust advised this was being resolved by pharmacist recruitment and expanded seven day working. Supply issues with radioisotopes were on the pharmacy risk register and action was being taken to find a solution to obtain appropriate supplies.

The medicines safety officer had a clear role in promoting safe medicines handling and disseminating learning from incidents.

**Information management**

The trust had a suite of performance reports and dashboards to monitor performance. Performance was reported to the board in an integrated performance report which covered a range of quality, performance, workforce and financial indicators.

The trust’s integrated performance report included 71 indicators summarised in a dashboard which recorded monthly performance, RAG (red, amber, green) ratings and monthly trends. For each indicator there was a graph or chart to show the performance against targets and a short narrative about the performance, reasons for variation and plans for improvement in the short and long term. Indicators were mapped to NHS Improvement and CQC standards. Performance measures reported and monitored by the trust included those set nationally, such as the four-hour A&E performance indicator and those set locally, such as mandatory training and appraisal rates. The trust had a process to review the indicators used in the report. Indicators in the integrated performance report were reviewed annually by the board committees and changes to the
indicators and the thresholds and targets were approved by the board. Directors were positive about the detail and presentation of data in the report to support them in their scrutiny and decision making. The trust told us that they planned to move to using statistical process control (SPC) charts to present the data.

There were a range of performance dashboards at clinical business unit level which supported the performance management process. Clinical business units had dedicated integrated performance reports which mirrored the trustwide report and financial dashboards which included a range of financial and performance information, including income, expenditure, activity and cost improvement programmes. Since July 2018 the trust had used service line reporting, service line reporting brings together the income generated by services and the costs associated with providing that service to patients, and reports this for each operational unit.

The trust published its safe staffing data, a mandatory requirement by NHS England, in a monthly report which included fill rates and care hours per person per day for each ward. The trust also cross referenced the data with the vacancy and sickness rate for each ward and actions taken to address risks with lower fill rates. The supporting board report also mapped patient harm to wards to identify if there was any links to staffing shortages.

The finance report to the board provided summary level financial information on key headings. There was a more detailed report considered by the finance committee which provided coverage of income and expenditure, working capital, capital expenditure, cost improvement and contract performance. The report provided comprehensive analysis of the financial position, however, it had little focus on remedial action and risk-based forecasting. There was also no visibility on the level of recurrent cost improvement plans which is a significant factor in achieving financial sustainability.

The trust had received positive third-party assurance on the robustness of its patient level costing system. The trust was making some use of clinical service line profitability analysis in cost improvement planning and intended to enhance this further.

The trust had processes for monitoring the quality of data and information which it used to monitor performance and reported externally. The trust created daily data quality reports which were reviewed by data quality clerks to check for missing data items and invalid data. The trust had separate groups which reported through the board committee structure which approved requests and changes for new data capture and reviewed activity and performance to investigate data and abnormal patterns. The trust also had a group, which had representatives of the clinical commissioning groups, which reviewed activity and financial information to understand and resolve anomalies. The trust annually tested a sample of data measures through the internal audit programme to provide assurance.

The trust used an external benchmarking tool which enabled the trust to review its position in relation to its peers, monitor mortality, referral patterns and activity variances, and sense check its data quality. The trust used model hospital data to support its understanding of variances which was reviewed by a use of resources group. The trust was moving to extend the use of a third party assured kite marking system to achieve best practice information governance standards.

The trust had successfully implemented an electronic patient record system and was working towards becoming paperless by 2020. Although this was not a fully integrated system the trust had achieved good connectivity with other clinical systems. There were plans to roll out this system to support electronic patient monitoring and virtual ward rounds. The trust secured innovation funding
as it was one of four trusts to achieve ‘digital exemplar’ status for the electronic patient record system it used.

The trust used the data from the electronic patient record and other information systems to support quality and performance by producing real time ward whiteboards, dashboards and other reports to support staff with investigating data accuracy, performance and activity variances, transformation, planning and future commissioning. Information analysts were aligned to the clinical business units to understand key issues with the area. At the time of the inspection the trust was piloting the use of whiteboards displaying real time flow in the emergency department. Electronic prescribing and medicines administration were being rolled out across the trust with full implementation expected by 2020. The trust planned to develop the functionality of the electronic patient record system to further enhance patient care. The trust also planned to use the business intelligence systems to create a data quality dashboard to provide clinical business units with greater performance intelligence.

The trust was using information systems to improve outpatient appointments and reduce do not attend rates. The trust had a digital system to check-in and in June 2018 the trust launched an electronic outpatient clinic scheduling system which supported the clinic and room booking using real time information. In June 2018 the trust launched a text reminder and feedback service which had reduced the do not attend rate from around 12% in 2016-17 to 8% which was in line with the National average. The trust also displayed live waiting times for its emergency department and urgent care centre to inform patients of the likely wait.

This trust was not affected by the 2017 WannaCry cyber-attack. It reported that it had applied the patches released earlier in the year, although but did take down several of its systems as a precaution over the weekend of the attack. The trust said patient care was not affected and it was able to return to business as usual with the restoration of email after the weekend. Following the attack, the risk was added to the board assurance framework but had since been removed.

The trust’s website supported functions to be accessed in different languages and for those with visual impairments.

Since the last inspection the trust had strengthened its process for acting on information from the central alerting system (a national web-based cascading system for issuing patient safety alerts). The trust had a new policy which was overseen by the patient safety and clinical effectiveness sub-committee or health and safety and wellbeing sub-committee depending on the type of alert. This was audited to ensure that alerts had been acted on.

The trust had processes to promote and support information governance at the trust. The trust had an information governance and corporate records committee which met bi-monthly and included the senior information risk owner and Caldicott Guardian (a senior person responsible for protecting the confidentiality of people’s health and care information) and other relevant staff. The committee reported to the quality assurance committee. The trust completed the annual data security and protection toolkit (previously known as the information governance toolkit) and had created actions plans to make improvements. In 2018-19 the trust had received moderate assurance from an internal audit of the toolkit, with areas for improvement in relation to supplier contract management and due diligence activities and dataflows.

All relevant pharmacy staff had access to summary care records and its use was well embedded into the trust. Medicine reconciliation rates were currently at 33% for the whole Trust; this is well below NICE national guidelines of 90% within 24 hours of patient admission and the trust target of
85%. Electronic transfer of medicines information was used to liaise with community pharmacy for the management of blister packs.

**Engagement**

The trust gathered people’s views and acted on them to shape and improve services. The trust had a patient and public participation and involvement strategy for 2019-2022. The strategy set out the approach to patient engagement and opportunities for public and patient involvement. In 2018 the trust had consulted a wide range of people and groups, including equality groups in the development of the trust’s strategy and other supporting strategies.

The trust’s patient experience sub-committee included staff and external partners such as governors and Healthwatch. At the time of the inspection the trust had five workstreams reporting to the group, focussing on putting the patient at the heart of everything the trust does. The trust had completed NHS Improvement’s patient experience assessment tool which the trust told us had not revealed any significant gaps in the services.

The trust hosted a series of public health engagement events each year called ‘Your Health’. Members of the trust, patients and the wider public were invited to attend sessions such as Warrington Together and One Halton, designing and redesigning services, and cancer services collaboration.

At September 2018 the trust had around 11,000 members. The trust planned to focus on increasing engagement with groups that were under-represented: the 17-21 age group, males of any age and those from minority ethnic groups.

The trust hosted regular ‘What Matters to Me?’ café style events supported by the governors to offer an opportunity to engage patients, visitors and staff. In 2018-19 the trust had engaged with patients and the public at both hospitals on topics including the new strategy, what matters to you in outpatients and the emergency department and a new hospital for Halton.

The trust had participated in the national experience of care week, with a conversation café in the emergency department and the Cheshire and Merseyside Treatment Centre being open to the public who had the opportunity to tour the building and meet surgical, therapy and radiography staff.

The trust was developing its approach to engaging with carers and was in the process of developing a carers strategy. The trust had two monthly carers cafes at both sites to engage and support carers. The trust had close links with carers organisations in Warrington and Halton to support carers in the community. The trust had a carers charter which supported staff in recognising the importance of involving carers in plans for hospital admissions and discharges and had carers champions.

The trust used local advocacy and working groups in the area to reach groups which were more difficult to engage, for example the Asian female population with cervical smears. The trust had worked with a disability group with patients walking through the patient journey and feeding back improvements that could be made.

The trust acted on feedback from national patient surveys. Following the 2018 CQC inpatient survey the trust had made changes such as finger food for patients living with dementia, a nutritional steering group being set up and menu cards in different languages. Within the 12 months before the inspection the trust carried out its own ‘dip-test’ surveys to assess
improvements in scores with the CQC inpatient survey. The trust said that the key findings indicated that there had been significant improvements made, with patients reportedly feeling that any fears and worries were being addressed and that they were treated with dignity and respect. The 2019 CQC inpatient survey had been shared with the trust but not published at the time of the inspection. In a number of the questions the positive responses had dipped slightly from the previous year but were broadly in line with responses nationally.

The trust had set up a task and finish group to assure the trust that it was meeting the accessible information standard. The accessible information standard was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. The trust was in the process of completing the work to implement and report to the patient experience committee.

The trust and senior leaders actively used different social media platforms to engage with patients, staff and the public. Posts included patient information, stories and staff successes.

The trust subscribed to an external engagement programme designed for use in the NHS and used widely at NHS trusts. The approach used engagement with clinicians and staff to make improvements to quality and safety, patient experience and team work. Eleven teams across the trust had been identified as pioneers within the programme to promote engagement and improvement within their area. Leaders and union representatives, we spoke to said that staff engagement had improved since the last inspection.

The trust used a range of methods of staff engagement with focus on equitable coverage across the two hospital sites. There was a team brief delivered by the executive team plus a range of more informal communications to staff on a regular basis. Staff at all levels had a good awareness of the operational, clinical and financial challenges faced by the trust.

The trust carried out a pulse check survey in addition to the staff survey to understand the views of staff. The pulse survey, which was part of the external engagement programme, was sent to all staff and asked 15 questions and invited three ideas for action. In the most recent pulse survey the response rate was 73% across the workforce, which was supported by a staff engagement campaign. The pulse survey had identified areas for improvement which the trust had an action plan for and generated 2,500 ideas which were being considered and put into practice.

In May 2019 the trust was holding a start of the year conference to share information about the strategies, inspections and celebrate the successes of teams as part of the engagement programme. A market place was planned for teams to share developments and future plans with other staff and leaders.

The trust held focus groups for engaging with staff with protected characteristics. The trust had held annual focus groups for staff with disabilities and Black and Minority Ethnic staff although did not currently have any formal engagement for other protected characteristics such as sexual orientation.

As a foundation trust, the trust was accountable to its members through a council of governors. The council of governors was made up of elected governors representing local people, trust members and staff. The trust had 16 public constituencies (five in the borough of Halton, nine in the borough of Warrington and two for the rest of England and Wales) and five staff constituencies (medical and dental, nursing and midwifery, support, clinical scientist or allied health professional and estates, administrative and managerial). The trust also had six partner governors who included local authorities and other partner organisations. Governor recruitment was promoted through the trust’s newspaper, on the website, in emails and at open days. Governors completed
the trust’s standard induction and mandatory training in addition to a governor core skills training workshop. New governors were offered the opportunity to attend regional development sessions and workshops and the national conference hosted by NHS Providers.

The council of governors had public meetings every two months with an agenda which included reports from the governor groups, chair and chief executive and other relevant business. The meetings were also attended by the non-executive directors. The three governor groups (quality in care, governor working group and governor engagement group) had oversight of the governors’ involvement in projects such as the development of strategies, local surveys and the annual quality accounts.

The council of governors was well-established and working relationships between the board and council were constructive and governors and leaders reported they had good engagement across the trust. The governors had a monthly open forum with the chief executive and chair, the lead governor attended the board meeting and governors were starting to attend committees of the board and the patient experience sub-committee, in an observer capacity. This enabled governors to discharge their responsibility for holding the non-executive directors to account.

The governors carried out unannounced observation visits across the trust where they monitored standards of care and talked to patients and staff. The council of governors selected two or three wards of departments each month and carried out unannounced visits at any time of the day or week. The governors completed a dashboard of their observations which was received at the patient experience sub-committee. The council of governors selected the ward or area based on a review of complaints and checked action had been completed. The dashboards formed part of the ward accreditation programme. Governors said staff felt listened to and were happy to talk to governors. Senior leaders said the visits were a valuable opportunity to triangulate other evidence such as complaints and incidents.

The trust had an annual members’ meeting in September each year where the annual report and accounts were presented to members and public.

The trust had a large volunteer workforce which it had developed with a local community interest company. The trust had increased the number of volunteers from 30 in 2016 to 587 in 2019 with volunteers providing more than 300 hours of their time each week. Of the volunteers 40% were aged between 16-25, 32% 26-44 years old, 20% 45-64 years old and 8% over 65 years old. The trust had plans to develop the volunteer service further with new roles and the introduction of pets as therapy.

The trust worked collaboratively with partners within the wider integrated care system and the local delivery system in Warrington and Halton. The pace of change within the wider strategic footprint of Cheshire and Merseyside was not as evident as other regions although the chief executive was leading the Cheshire and Merseyside Partnership and the trust’s senior leadership team were well connected to relevant work programmes.

The trust was a key member of the place-based care systems in Warrington and Halton and was working with the local authorities, GP federations, other health providers and other organisations to move towards integrated systems of care. The trust reported that they were ‘maturing partnerships’ within the two systems. The trust demonstrated an example of a success in Warrington with the opening of the frailty unit with an investment of £1 million from the integrated commissioning transformation board following a successful pilot. The joint bid was led by the Warrington care system.
Services for Warrington and Halton were commissioned by two clinical commissioning groups. The trust reported that it had been challenged by servicing two commissioner relationships but that the two clinical commissioning groups were aligning with a shared executive team function. Contractual arrangements with the host commissioners were reported to have improved. There was a two-year sustainability contract in place which was good evidence of a joined-up approach to risk sharing.

The trust worked with other NHS providers in the area to improve services across the area. Leaders were clear about the importance of developing relationships across organisations to support integration and partnership working. The trust was developing its relationship with the local NHS community health service provider with plans future for integration. The trust had a memorandum of understanding which included the establishment of a provider collaboration board to govern a programme of collaborative work between the trusts. The programme of work included five work streams: co-location, back office collaboration, joint appointments, vertical pathway design and transformation. The trusts had also had executive-to-executive and board-to-board meetings during the inspection period. The trust was also working with the neighbouring acute NHS trust with the sharing of some functions and the establishment of an acute sustainability programme, set up with staff from different clinical specialties across the trusts.

The trust had strong partnerships with the voluntary sector. The trust highlighted its work with a Warrington based disability charity to support reablement and independence for patients and support for staff with disability. The trust had worked with the charity to open an independent living centre in its outpatient department and developing an in-reach service. The trust also had strong links with local carers organisations who were embedded in the discharge lounges and had in-reach services to the wards. The charity ran an annual disability day with the trust which provided an opportunity for the trust to discuss its services with users and the public. The trust had also recruited members of the disabled community to its workplace experience and apprenticeship programmes.

The trust had strong relationships with Healthwatch in Warrington and Halton. Healthwatch in Warrington and Halton attended the trust’s patient experience sub-committee every month and shared information from the enter and view visits at both sites. The trust reported that it was working with Healthwatch Warrington to establish an independent patient panel as a consultative body.

The medicines safety officer attended regional meetings to share learning. The chief pharmacist worked collaboratively with local trusts and the local sustainability and transformation programmes. Patient satisfaction surveys were carried out and reviewed by the pharmacy team to drive quality improvements. Aseptic services were identified by the trust as needing development within the trust and in collaboration with the wider Cheshire and Merseyside Health and Social Care Partnership.

Learning, continuous improvement and innovation

The trust was focussed on making improvements to its services and in particular the services rated requires improvement at the last CQC inspection. This was reflected in the improvement strategy “getting to good moving to outstanding”. Leaders were candid that the last inspection was a realisation of the changes that needed to be made to improve quality and was a catalyst for change at the trust. Following the inspection, the trust developed an action plan incorporating the regulatory breaches, actions CQC said the trust should take and any other areas for improvement.
identified in the report. The trust set up a “getting to good, moving to outstanding” steering group to monitor the actions, which reported to the board.

Quality improvement, clinical audit, research and development, innovation and knowledge management were all part of the trust’s quality academy which was established in Autumn 2018. The academy had a vision to “enable cutting edge research and innovation, embedding excellence in care through continuous quality improvement, working with staff, our partners and the public”. The performance of the academy against its strategy was overseen by the quality academy board, executive leads and director of governance and quality and monitored using a dashboard. The quality academy’s objectives were set out in the trust’s quality strategy.

The trust was committed to quality improvement which was supported by the associate medical director for strategy and quality improvement and two quality improvement facilitators. The trust had trained more than 350 staff in quality improvement methodology at four levels dependent on job role: foundation, practitioner, advanced and expert. Training was delivered to staff at different levels internally and with a North West based quality improvement organisation. The trust had standardised tools and methods for quality improvement using the methodology of an international healthcare improvement organisation. The trust gave an example of effective use of quality improvement methodology of processes within ophthalmology which identified that two new consultants post which had been identified were not needed, with the change in processes.

The trust had an intellectual property policy which was due to be approved at the time of the inspection and had recently developed a pathway for innovation, which detailed how a member of staff could take their idea through from concept through to creation. The trust held quarterly ‘Dragon’s Den’ style and hackathon (events to develop software products) events to promote innovations as well as regular innovation breakfasts.

The trust was the first NHS provider in the country to offer ear mould scanning. This enabled moulds of patients’ ears to be scanned and sent digitally to the manufacturers to process reducing waiting times. The service benefited children and patients living with dementia who are more likely to lose their aids, as the image is scanned on to the system they do not have to return to hospital to have another scan to replace their hearing aids.

The trust had a team of around seven whole time equivalent nurses and two new clinical fellows to support clinical research trials. The trust had met with local universities and advertised medical roles with research time to increase the participation and profile of research and development within and outside of the trust.

The trust had relaunched quarterly learning to improve newsletter which set out learning from a range of incidents, complaints, mortality reviews and audit. The newsletter detailed previous incidents and themes across the trust and set out the actions taken and learning to prevent them reoccurring. In October 2018 the trust also hosted a safety summit to share learning across services, focussing on the lessons learnt from the serious incidents in spinal surgery.

The clinical governance department monitored serious incidents daily using information in the incident reporting system. Incidents that met the serious incident threshold and outcomes were discussed at the weekly meeting of harm, chaired by the chief nurse. At the meeting the contact with patients and families was overseen and discussed. The trust generated a weekly serious incident dashboard which was sent to senior clinicians and managers for the clinical business units. The governance team sent a weekly report to board members and senior managers of all new serious incidents, complaints, claims and duty of candour compliance. The monthly patient safety and clinical effectiveness sib-committee also received a monthly report of serious incident
performance and duty of candour compliance. An audit of lessons learned from serious incidents was carried out every three months and reported to the quality assurance committee.

We reviewed a sample of serious incidents which had been investigated using root cause analysis. In each case we found that the investigation established the cause and effect and where appropriate identified learning and improvements from the incident with recommendations and an action plan. Investigations had clear terms of reference, were clearly written and easy to read and investigators were suitably independent. While the quality of investigations was good, we found that the documentation used to record investigations did not have a section to record any safeguarding or capacity issues and it was unclear whether patient and their family or carers were involved in agreeing the terms of reference for every investigation. We also found that the definition for septicaemia was not accurate in the form.

The trust had a policy and structures to support learning from deaths. National learning from deaths guidance required NHS trusts to produce and publish an updated policy on learning from death. The trust reviewed deaths which it deemed higher risk or within specific categories using a structured judgement review process. The trust had given dedicated time to the clinician leading the process and to nine other clinicians to complete reviews. Learning from deaths was reviewed by the trust’s mortality review group which reported into the board’s committee structure via the quality assurance committee. The process linked to the serious incident process which would be triggered if there were instances of poor or very poor care. The trust undertook focused reviews when mortality data indicated emerging issues in particular diagnostic groups and reported it had done so on five occasions in the year before the inspection. In the last year the trust had engaged with families of bereaved patients about the learning from deaths process and as a result had made changes to the information given to families.

We reviewed a sample of structured judgement reviews completed by the trust and found the process enabled the trust to clearly identify failings in care using a grading system and share learning from the death. From the information we reviewed the reviewers appeared to have reached reasonable views in all but one of the cases where some issues not picked up by the reviewer may have been following a review by a senior clinician.

The trust participated in “getting it right first time” (GIRFT). GIRFT is a national programme designed to reduce variations in care within the NHS. A number of specialties including urology, ophthalmology, trauma and orthopaedics, obstetrics and gynaecology, ear, nose and throat, general surgery and emergency medicine had received a visit from the GIRFT team and the trust were positive outliers in oral surgery and ear, nose and throat for access to services and having effective pathways of care in place.

The trust had a process for acting on the findings from GIRFT visits. Following receipt of the observation notes from a GIRFT deep dive visit, the quality academy, clinical business units and specialty leads agreed actions which were monitored quarterly through the patient safety and clinical effectiveness sub-committee. The trust gave examples of actions such as in general surgery new upper gastrointestinal consultants being employed to assist with the number of consultants who were able to remove gallbladders. In addition, the management of the list of patients and allocation was being organised and revamped to ensure the correct consultants were allocated.

The trust had established partnerships with schools, colleges and universities in the region. The trust did not currently have teaching hospital status but trained a range of healthcare professionals such as nurses, midwives, biomedical scientists, pharmacists, dieticians in partnership with local universities.
The trust was participating in the training to support workforce diversification. This included a physician associate post graduate course at the medical faculty and a scheme with a local NHS trust to employ doctors from India on a two-year programme where the doctor works within the NHS, works towards a higher qualification before returning home. The trust had four qualified doctors on the programme. The trust had signed a memorandum of understanding with a local college to create a partnership to support the trust to create a career pipeline and the college to offer educational and learning experiences to students seeking healthcare work experience.

The trust was setting up a social entrepreneurship start up in partnership with a local community interest company granting small amounts of money for individuals or groups, staff, volunteers, patients, partners or visitors who set up a programme or service which helps to improve the wellbeing of staff, patients or community.

Trust had developed pharmacy technician medicines administration on three wards; this supported nursing staff to spend time on other tasks. Pharmacy technicians were able to support and counsel patients regarding their medicines and supported staff with the wider management of medicines.

Paediatric pharmacy staff had led on a number of projects and improvements such as setting up a paediatric pharmacist network, developing a paediatric seizure box and developing a paediatric antibiotic formulary. Pharmacy staff were supporting the frailty assessment unit and links were being developed with community teams to set up integrated frailty teams.

Pharmacy staff were involved with prescribing courses at a local university.

There was a strong culture of learning within the pharmacy team with the majority of pharmacist staff enrolled on a clinical diploma course and all pharmacy staff having access to regular internal learning sessions.

The trust was nominated and won a range of National healthcare awards in 2018. This included the winner at a national award in the primary care innovation category for the partnership with a local rugby league team with a campaign to improve awareness of A&E. The maternity services won a national award for the best hospital bereavement service for supporting families experiencing baby loss and in a national patient safety award there were two finalists, in the infection prevention and control category for the intensive care team’s work in reducing methicillin-susceptible Staphylococcus aureus and the perioperative and surgical care category for transfuse and check. In a national nursing awards the trust was finalist in five categories for best UK employer for developing and introducing multi-professional clinical skill pathway, best employer for staff recognition for introducing a multidisciplinary clinical skills and leadership programme for aspirational care deliverers, best workplace for learning and development for Introducing a multidisciplinary core competency framework, investing in the workforce of the future for developing a multi-professional aspirational leadership programme and workforce team of the year for introducing a multidisciplinary core competency framework.

The wider finance function had good engagement in staff development activities. The procurement team had been awarded level one accreditation. The finance team were accredited at level two by the NHS Skills Development Network and had been shortlisted as a healthcare financial management association team of the year. This indicates high performing teams who are adding value in the trust.

**Complaints process overview**

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

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>Three working days to formally acknowledge a complaint</td>
<td>Of the 419 complaints received from January 2018 to December 2018, 99.5% of the complaints were acknowledged on time.</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>60 working days for high graded complaints and 30 working days for moderate and low graded complaints</td>
<td>From January 2018 to November 2018 there have been 499 complaints responses that needed to go out from the trust. 296 of these went out on time making a timeliness percentage of 59%. This has been an improving trajectory.</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints, please indicate what that is here</td>
<td>60 working days for high graded complaints</td>
<td>From January 2018 to November 2018, 67 high graded complaints were responded to 46 of which were responded to on time (69%). This has been an improving trajectory.</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>1,324 complaints (December 2017 to December 2018)</td>
<td>(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)</td>
</tr>
</tbody>
</table>

The trust had made significant improvement in resolving the backlog of complaints we found at the last inspection. At the end of 2018-19 the trust had no cases over 6 months old, 86 complaints awaiting a response and 16 cases which had breached timescales but discussions with complainants had taken place. The trust had made the increase in timeliness of complaints a local quality priority in 2019-20.

We reviewed a sample of complaints and found that in each complaint the issues were identified and confirmed with the complainants. Complaint responses were clear, open and apologised when things went wrong. All complainants were given information about how to be supported with making complaints and offered meetings at an early stage. An audit of lessons learned from serious incidents was carried out every three months and reported to the quality assurance committee. We saw evidence of joint responses and work with other stakeholders to resolve issues. Every complaint was risk assessed and 72-hour reviews were completed by the clinical team for high risk complaints.

**Number of complaints made to the trust**

The trust received 428 complaints from December 2017 to December 2018. Urgent and emergency services core service received the most complaints with 96 (22.4% of total complaints).

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

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency services</td>
<td>96</td>
<td>22.4%</td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>83</td>
<td>19.4%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>7</td>
<td>1.6%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>6</td>
<td>1.4%</td>
</tr>
<tr>
<td>Critical care</td>
<td>4</td>
<td>0.9%</td>
</tr>
<tr>
<td>End of life care</td>
<td>2</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>428</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The top three complaint types trust wide can be seen in the table below:

<table>
<thead>
<tr>
<th>Complaint type</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>270</td>
<td>63.1%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>43</td>
<td>10.0%</td>
</tr>
<tr>
<td>Appointments</td>
<td>42</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

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

**Compliments**

From January 2018 to December 2018, the trust received a total of 291 compliments.

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

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people's care)</td>
<td>200</td>
<td>68.7%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>20</td>
<td>6.9%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>18</td>
<td>6.2%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>18</td>
<td>6.2%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>15</td>
<td>5.2%</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>2.4%</td>
</tr>
<tr>
<td>Surgery</td>
<td>6</td>
<td>2.1%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>4</td>
<td>1.4%</td>
</tr>
<tr>
<td>Maternity</td>
<td>3</td>
<td>1.0%</td>
</tr>
<tr>
<td>Critical care</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>291</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The themes from trust compliments from the time period are largely to do with patients and relatives giving feedback about outstanding care. The trust is currently working on developing a system to more formally record all compliments received into the trust.

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

**Accreditations**

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

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>ISO15189:2012 for all four pathology departments</td>
</tr>
<tr>
<td><strong>Biochemistry</strong></td>
<td>Accreditation granted July 2018. Letter received from UKAS Accreditation Manager Accreditation maintained following Surveillance Visit – December 2018</td>
</tr>
<tr>
<td><strong>Haematology</strong></td>
<td>Accreditation granted September 2018. Letter received from UKAS Accreditation Manager Surveillance Visit scheduled for January 2019</td>
</tr>
<tr>
<td><strong>Microbiology</strong></td>
<td>Accreditation granted August 2018. Letter received from UKAS Accreditation Manager Surveillance Visit scheduled for January 2019</td>
</tr>
<tr>
<td><strong>Histopathology and Mortuary</strong></td>
<td>Accreditation granted September 2018. Letter received from UKAS Accreditation Manager Surveillance Visit scheduled for February 2019</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Accreditations tab)*
Warrington Hospital

Medical care (including older people’s care)

Facts and data about this service

The medical care and integrated medicine and community clinical business units are responsible for the delivery of cardiology, respiratory, diabetes and endocrinology, sexual health, older peoples care, stroke, rehabilitation, intermediate care, frailty and patient flow.

The medical specialities clinical business unit is supported by a team of consultants and nurse consultants (diabetes, dementia and frailty).

With the exception of the acute medicine floor the two clinical business units are responsible for ten medical wards at Warrington and Halton including the new 26 bedded acute cardiac care unit that opened in December 2018 following a £0.75m capital investment.

The frailty unit on the Warrington site opened in June 2018 offering an integrated approach to frailty, targeting patients who would benefit from services that enable them to remain in the community, reducing avoidable hospital attendance through access to rapid assessment, diagnostics, pharmacy, 24hr respite care and ‘Step Up’ care provision.

NHS England transformation funding has provided additional support for inpatient diabetes care.

The development of the ‘medically optimised’ C22 WREN unit using a reablement model to ensure safe, effective discharges with a ‘home first’ approach is a further step in developing integrated services for the borough working closely with partners to optimise patients for discharge.

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

The trust had 23,608 medical admissions from August 2017 to July 2018. Emergency admissions accounted for 12,132 (51.4%), 215 (0.9%) were elective, and the remaining 11,261 (47.7%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 12,417
- Gastroenterology: 5,198
- Clinical haematology: 2,222

(Source: Hospital Episode Statistics)
Is the service safe?

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

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

Trust level

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th></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>
<td></td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>98</td>
<td>100</td>
<td>98.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Infection prevention and control - level 1 - 3 years</td>
<td>16</td>
<td>17</td>
<td>94.1%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>117</td>
<td>125</td>
<td>93.6%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>121</td>
<td>130</td>
<td>93.1%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Counter fraud - No renewal</td>
<td>115</td>
<td>125</td>
<td>92.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Moving and handling - level 1 - 3 years</td>
<td>20</td>
<td>22</td>
<td>90.9%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>NHS conflict resolution (England) - 3 years</td>
<td>101</td>
<td>112</td>
<td>90.2%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>115</td>
<td>128</td>
<td>89.8%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>70</td>
<td>79</td>
<td>88.6%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>113</td>
<td>128</td>
<td>88.3%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>122</td>
<td>140</td>
<td>87.1%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Infection prevention and control - level 2 - 1 year</td>
<td>88</td>
<td>102</td>
<td>86.3%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - 3 years</td>
<td>174</td>
<td>203</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Medicines management awareness - No renewal</td>
<td>83</td>
<td>108</td>
<td>76.9%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Resus level 2</td>
<td>63</td>
<td>86</td>
<td>73.3%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In medicine the 85% target was met for 13 of the 15 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 at trust level for medical staff in medicine is shown below:
## Training module name

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Infection prevention and control - level 1 - 3 years</td>
<td>11</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>115</td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>104</td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>110</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - 3 years</td>
<td>84</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>110</td>
</tr>
<tr>
<td>NHS conflict resolution (England) - 3 years</td>
<td>93</td>
</tr>
<tr>
<td>Counter fraud - No renewal</td>
<td>109</td>
</tr>
<tr>
<td>Moving and handling - level 1 - 3 years</td>
<td>20</td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>94</td>
</tr>
<tr>
<td>Medicines management awareness - No renewal</td>
<td>65</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>98</td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>72</td>
</tr>
<tr>
<td>Resus level 2</td>
<td>88</td>
</tr>
<tr>
<td>Infection prevention and control - level 2 - 1 year</td>
<td>85</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - No renewal</td>
<td>3</td>
</tr>
</tbody>
</table>

In medicine the 85% target was met for nine of the 16 mandatory training modules for which medical staff were eligible.

**Warrington Hospital medicine department**

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 for qualified nursing staff in the medicine department at Warrington Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>85</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>104</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>111</td>
</tr>
<tr>
<td>Infection prevention and control - level 1 - 3 years</td>
<td>14</td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>65</td>
</tr>
<tr>
<td>Counter fraud - No renewal</td>
<td>102</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>106</td>
</tr>
</tbody>
</table>
At Warrington Hospital medicine department, the 85% target was met for 13 of the 15 mandatory training modules for which qualified nursing staff were eligible.

The trust provided mandatory training for staff and managers ensured staff completed this. This had improved since the last inspection, where we found completion of mandatory training did not meet trust targets.

Ward managers actively monitored staff compliance with mandatory training and we saw compliance with mandatory training for nursing staff was high and met trust targets. Managers reviewed staff completion of mandatory training at annual appraisals and staff received email reminders to prompt them when their mandatory training was due. Additional initiatives had been implemented in some wards to promote mandatory training, including a training board in staff rooms to encourage completion.

Practice education facilitators supported ward managers in identifying training needs and completion of mandatory training.

The trust report that medical staff in medicine work across both Warrington and Halton sites to allow for flexibility. Where possible, the trust has associated the departments to services/wards but in most cases the trust has allocated the site based on where the majority of work is completed. This has meant that most medical staff working in medicine have been assigned to the Warrington Hospital site.

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 for medical staff in the medicine department at Warrington Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Infection prevention and control - level 1 - 3 years</td>
<td>11</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>113</td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>102</td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>108</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - 3 years</td>
<td>84</td>
</tr>
</tbody>
</table>
At Warrington Hospital medicine department, the 85% target was met for nine of the 16 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. This had improved since the last inspection where we found not all staff were compliant with the right level of safeguarding training.

We reviewed ward level records of safeguarding training for staff during inspection. These confirmed staff were compliant and up-to-date with the trust target for all safeguarding modules required. This included level one and two safeguarding adults, level one and two safeguarding children, preventing radicalisation level one and two; preventing radicalisation level three and four.

Staff were aware of the type of safeguarding issues which could arise in medical services and they were confident in describing safeguarding procedures at ward level. We saw examples in patient records where safeguarding concerns which had been followed up appropriately. Individual members of staff were identified as safeguarding champions onwards, to share safeguarding information and best practice. Members of the trust’s adult safeguarding team were also available for any additional support when this was required.

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.

Trust level

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

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Total</th>
<th>Qualified Staff</th>
<th>Completion Rate</th>
<th>Target</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia awareness - No renewal</td>
<td>104</td>
<td>117</td>
<td>88.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS conflict resolution (England) - 3 years</td>
<td>91</td>
<td>104</td>
<td>87.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 1 - 3 years</td>
<td>20</td>
<td>23</td>
<td>87.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Counter fraud - No renewal</td>
<td>101</td>
<td>117</td>
<td>86.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>92</td>
<td>109</td>
<td>84.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management awareness - No renewal</td>
<td>65</td>
<td>77</td>
<td>84.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>96</td>
<td>115</td>
<td>83.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>70</td>
<td>86</td>
<td>81.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus level 2</td>
<td>86</td>
<td>107</td>
<td>80.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention and control - level 2 - 1 year</td>
<td>83</td>
<td>104</td>
<td>79.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - No renewal</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
### Warrington and Halton Hospitals NHS Foundation Trust Evidence Appendix July 2019

In medicine the 85% target was met for all of the six safeguarding training modules for which qualified nursing staff were eligible.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>113</td>
<td>115</td>
<td>98.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>113</td>
<td>118</td>
<td>95.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>83</td>
<td>92</td>
<td>90.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>90</td>
<td>100</td>
<td>90.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>79</td>
<td>92</td>
<td>85.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In medicine the 85% target was met for five of the seven safeguarding training modules for which medical staff were eligible.

Warrington Hospital medicine department

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 for qualified nursing staff in the medicine department at Warrington Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding children - level 3 - 3 years</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>102</td>
<td>111</td>
<td>91.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>110</td>
<td>120</td>
<td>91.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>122</td>
<td>136</td>
<td>89.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>62</td>
<td>71</td>
<td>87.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>98</td>
<td>124</td>
<td>79.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>91</td>
<td>124</td>
<td>73.4%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 85% target was met for five of the seven safeguarding training modules for which medical staff were eligible.

Warrington Hospital medicine department

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 for qualified nursing staff in the medicine department at Warrington Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>99</td>
<td>101</td>
<td>98.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>100</td>
<td>104</td>
<td>96.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
At Warrington Hospital medicine department, the 85% target was met for all of the six safeguarding training modules for which qualified nursing staff were eligible.

The trust report that medical staff in medicine work across both Warrington and Halton sites to allow for flexibility. Where possible, the trust has associated the departments to services/wards but in most cases the trust has allocated the site based on where the majority of work is completed. This has meant that most medical staff working in medicine have been assigned to the Warrington Hospital site.

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 for medical staff in the medicine department at Warrington Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children - level 3 - 3 years</td>
<td>2</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>100</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>108</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>120</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (prevent awareness)</td>
<td>62</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>96</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>89</td>
</tr>
</tbody>
</table>

At Warrington Hospital medicine department, the 85% target was met for five of the seven safeguarding training modules for which medical staff were eligible.

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

Following the inspection, the trust provided an update of safeguarding training for medical staff, to reflect the recently published Adult Safeguarding: Roles and Responsibilities for healthcare staff, first edition: August 2018 Inter-collegiate document. The trust confirmed four staff had already completed safeguarding adults level three training, and continued compliance rates were being monitored through existing governance processes.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

All the medical wards we visited were visibly clean and orderly.
The trust had an infection prevention and control policy and we observed staff followed trust guidance for arms ‘bare below the elbows’ when providing treatment and care to patients.

During inspection we saw systems were in place to manage risk of infection in the acute medical unit, where one bay was closed, and patients were isolated to one bay to limit the spread of infection. We observed staff following infection prevention and control protocols when caring for these patients, wearing aprons and gloves, also keeping the bay doors closed. Prominent notices were displayed at the ward entrance to remind visitors and staff to use hand gel and observe handwashing, before entering and leaving the ward areas.

Handwashing facilities, hand gel and protective personal equipment, such as aprons and gloves, were readily available in all the wards we visited. We saw staff, in general, washing their hands and using hand gel in between patient contacts. Patient equipment was labelled and dated with “I am clean” stickers, when cleaned after each patient use.

The trust monitored handwashing compliance through regular monthly infection prevention and control audits, with results shared to local wards. Information from audit reports showed during December 2018 to February 2019, there were two occasions when compliance with audit was below 90%; this was for ward B12 in February 2019 (85%) and ward B14 in January 2019 (84%). The following month, we saw these scores had improved to 100%.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

The environment was appropriate on the wards we visited, and the equipment provided was suitable for providing care to medical patients. The hospital had clear directions and signposting to medical wards and departments, with lifts available for access. Ward areas were clearly identifiable and had suitable reception areas, with entry and exit controls.

We checked resuscitation equipment in the wards we visited and saw resuscitation trolleys were located appropriately for access in an emergency. Staff checked resuscitation equipment and maintained accurate and up-to-date records of the daily and weekly checks.

Telemetry monitoring equipment, and other specialist equipment on the cardiac care unit and respiratory ward, was serviced and maintained in accordance with manufacturers’ guidelines. The hospital’s biomechanical engineering department provided response in the first instance to any breakdown of this equipment and there were contingency arrangements in place for back up equipment, if needed in an emergency.

The cardiac care unit and frailty assessment unit had been designed in consultation with staff working with patients living with dementia, to provide an appropriate environment. Rooms were well lit and decorated with bold colours, with matt finish on floors. Locations of toilets and bathrooms were clearly indicated for patients, with symbols and coloured images.

We checked other equipment available on the ward for patient use, including blood pressure machines, commodes and hoists. We saw electronic equipment was safety tested. All equipment we observed was stored in a safe and orderly manner in ward areas. In one isolated exception, we noted several walking sticks were propped up in the corner of the dirty utility room on AMU.

Housekeeping staff-maintained schedules for environmental cleaning of wards and departments. We saw these were completed and up-to-date where we reviewed records. We observed housekeepers completing a deep clean of a ward bay; this task was conducted to a thorough...
standard and staff were seen to maintain patients’ comfort and dignity whilst completing their activities.

**Assessing and responding to patient risk**

The service monitored the condition of patients using a national early warning scores system (NEWS2). This system aims to identify changes in patients’ condition and deteriorating patients quickly. Introduced in 2018 as a national programme to replace NEWS, NEWS 2 had been fully implemented in the service.

The trust had a procedure for recognising and responding to deteriorating patients, with guidance for escalating any patients with a national early warning score greater than zero. The procedure also included reference to patients who gave cause for concern without a raised national early warning score and those whose condition did not improve despite intervention. The procedure was based on best available evidence and current national guidelines.

Patients were reviewed and discussed in nursing safety briefings and board rounds three times a day. We saw that information regarding any changes in patients’ conditions, including a changing NEWS score and any follow up actions or escalation, was shared during the safety briefing.

We reviewed six records in patient areas and saw that patients’ national early warning scores were documented correctly, with escalation followed up appropriately where needed.

The trust monitored the application of the national early warning scores system on medical wards through audit, with these results used to identify improvements. Data provided by the trust showed appropriate actions were identified to improve performance.

Staffing levels in areas of higher patient dependency, including the cardiac care unit and the respiratory ward, were managed to ensure there was an appropriate number of staff available for the level of patient care required. Shifts were allocated to ensure there was always a member of nursing staff with advanced life support training available on every shift, and to respond to any emergencies.

The trust had a sepsis pathway in accordance with UK Sepsis Trust guidelines and monitored performance against this. Staff in different wards were identified as sepsis champions throughout the service. Champions shared information with other staff members about best practice in relation to sepsis. All nursing staff were issued with a small information card to prompt them about signs of sepsis, and what actions to take if sepsis is suspected.

Nursing staff completed risk assessments for patients on admission recording these on an electronic recording system. These documented patient risks for falls, nutrition, pressure ulcers and venous thromboembolism (VTE).

The service followed an enhanced care risk assessment which identified the level of care or observation an individual patient may need. Patients were assessed, and according to their care and dependency needs, their results were graded on a scale of one to four. Patients with the highest level of care need were assessed as grade four, requiring continuing one-to-one care from staff, whilst patients graded at level one required only to be visually monitored through the day and have routine observations completed.

“Call don’t fall” signs were displayed prominently in-patient areas to inform patients at risk of falls to call staff when mobilising to help reduce incidence of patient falls.
Nurse staffing

Planned vs actual

The trust has reported their nursing staffing numbers below, by ward, from April 2017 to March 2018 and from April to November 2018 in medicine at Warrington Hospital. The service had a fill rate of 83.9% from April 2017 to March 2018, which had decreased to 80.4% by November 2018.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Acute cardiac care unit - Ward A3</td>
<td>22.7</td>
<td>23.6</td>
</tr>
<tr>
<td>Cardiac catheter lab</td>
<td>5.5</td>
<td>5.0</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>1.6</td>
<td>1.6</td>
</tr>
<tr>
<td>Discharge suite</td>
<td>1.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Endoscopy unit</td>
<td>24.4</td>
<td>24.1</td>
</tr>
<tr>
<td>Ward A1 (AMU)</td>
<td>29.8</td>
<td>20.2</td>
</tr>
<tr>
<td>Ward A2</td>
<td>19.8</td>
<td>14.7</td>
</tr>
<tr>
<td>Ward A4</td>
<td>22.7</td>
<td>15.2</td>
</tr>
<tr>
<td>Ward A7</td>
<td>25.0</td>
<td>18.6</td>
</tr>
<tr>
<td>Ward A8</td>
<td>18.8</td>
<td>11.8</td>
</tr>
<tr>
<td>Ward B12</td>
<td>13.7</td>
<td>14.4</td>
</tr>
<tr>
<td>Ward B14</td>
<td>16.3</td>
<td>13.1</td>
</tr>
<tr>
<td>Ward B18</td>
<td>22.8</td>
<td>19.9</td>
</tr>
<tr>
<td>Ward B19</td>
<td>13.7</td>
<td>14.7</td>
</tr>
<tr>
<td>Ward C22</td>
<td>13.7</td>
<td>14.0</td>
</tr>
<tr>
<td>Total</td>
<td>251.9</td>
<td>211.3</td>
</tr>
</tbody>
</table>

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

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the data in the appropriate format.

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

Turnover rates

From December 2017 to November 2018, the trust reported a turnover rate of 16.6% in medicine. This is higher than the trust target of 13%.

- Warrington Hospital: 17.0%

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

Sickness rates

From December 2017 to November 2018, the trust reported a sickness rate of 4.7% in medicine. This is slightly higher than the trust target of 4.3%.

- Warrington Hospital: 4.5%
The service did not always have enough staff with the right qualifications, skills, training and experience to meet its planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.

The service used a safer staffing tool to monitor staffing levels and where necessary move staff to areas of staff shortage or to meet higher levels of patient acuity. Managers reviewed staffing levels throughout the day; systems for managing any staffing issues were established and appeared to be working well. Despite this however, we saw during inspection that planned and actual levels of staffing were not always fulfilled, also staff were often moved during shifts to other areas of higher demand. This was more evident in particular wards, including the acute medical unit. In January 2019 a total of six staff (four qualified and two healthcare assistants) were moved from AMU; in February 2019 there were five staff moves (one band 4, one registered nurse and one healthcare assistant); in March 2019 there were two staff moves (one band 4 and one healthcare assistant).

Ward managers on acute medical assessment unit informed us of current recruitment of qualified nursing staff, further to a staffing review in 2018 completed by the chief nurse. A total of seven new nurses were anticipated to join the team over coming months and by September 2019. Ward managers remained supernumerary, however reported that they were often needed to supplement staffing numbers due to sickness or other leave. Their availability for this was planned for and did not impact on their other management duties. We saw that although there were gaps in staffing, any shortage of staff did not have adverse impact on patients and nurses worked well together to ensure patient care was prioritised.

Data provided by the trust confirmed the lowest average daily shift fill rate in medical wards for registered nurses, between November 2018 and March 2019, was 75.4% (November 2018 - ward A8). The most recent data for March 2019 showed the lowest average daily shift fill rate was 84.6% (March 2019 - ward A7 respiratory).

During our inspection, the wards we visited displayed information about their staffing levels. In all areas we visited we saw staff worked together effectively to prioritise patient safety and care.

Bank and agency staff usage

Warrington Hospital

From December 2017 to November 2018, the trust reported 30,624 (6.1%) bank hours and 39,023 (7.8%) agency hours were filled by qualified nursing staff in medicine at Warrington Hospital. There were 40,602 (8.1%) hours that were left unfilled.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Ward/Unit</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>NOT filled by bank/agency usage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>ACCU - Acute Cardiac Care Unit - Ward A3</td>
<td>48,743</td>
<td>2,597</td>
<td>5.3%</td>
<td>187</td>
</tr>
<tr>
<td>Cardiac Catheter Lab</td>
<td>10,538</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>3,060</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
</tr>
</tbody>
</table>
Ward A1 (AMU) & 55,616 & 3,114 & 5.6% & 11,859 & 21.3% & 7,050 & 12.7% \\
Ward A2 & 38,779 & 2,694 & 6.9% & 5,581 & 14.4% & 3,805 & 9.8% \\
Ward A4 & 43,183 & 2,892 & 6.7% & 5,333 & 12.3% & 4,926 & 11.4% \\
Ward A7 & 48,858 & 3,771 & 7.7% & 4,165 & 8.5% & 4,383 & 9.0% \\
Ward A8 & 43,656 & 5,824 & 13.3% & 11,859 & 21.3% & 5,182 & 11.9% \\
Ward B12 & 26,801 & 1,714 & 6.4% & 219 & 0.8% & 679 & 2.5% \\
Ward B14 & 28,445 & 2,240 & 7.9% & 1,240 & 4.4% & 3,289 & 11.6% \\
Ward B18 & 46,914 & 1,802 & 3.8% & 904 & 1.9% & 5,902 & 12.6% \\
Ward B19 & 27,621 & 1,352 & 4.9% & 1,167 & 4.2% & 1,906 & 6.9% \\
Ward C22 & 30,428 & 2,623 & 8.6% & 3,069 & 10.1% & 2,585 & 8.5% \\
Discharge Suite & 1,562 & 0 & 0.0% & 0 & 0.0% & 0 & 0.0% \\
Endoscopy Unit & 46,257 & 0 & 0.0% & 0 & 0.0% & 0 & 0.0% \\
Frailty Assessment Unit & 0 & 0 & N/A & 0 & N/A & 16 & N/A \\
**Total** & 500,460 & 30,624 & 6.1% & 39,023 & 7.8% & 40,602 & 8.1% \\

Ward A8 had the highest bank usage with 13.3% of available hours and ward A1 (AMU) had the highest agency usage with 21.3% of available hours. There were five wards at Warrington Hospital which had over 10% hours unfilled.

During the same period, the trust reported 108,207 (25.8%) bank hours and 12 (0.0%) agency hours were filled by nursing assistants in medicine at Warrington Hospital. There were 57,059 hours (13.6%) that were left unfilled.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Ward/Unit</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>NOT filled by bank/agency usage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
</tbody>
</table>
| Acute Cardiac Care Unit - Ward A3 | 5,208 & 1,059 & 20.3% & 0 & 0.0% & 1,825 & 35.0% \\
| Cardiac Catheter Lab | 5,049 & 0 & 0.0% & 0 & 0.0% & 0 & 0.0% \\
| Ward A1 (AMU) | 50,860 & 7,642 & 15.0% & 0 & 0.0% & 5,428 & 10.7% \\
| Ward A2 | 30,740 & 10,427 & 33.9% & 0 & 0.0% & 4,892 & 15.9% \\
| Ward A4 | 30,906 & 8,958 & 29.0% & 0 & 0.0% & 4,444 & 14.4% \\
| Ward A7 | 35,898 & 9,200 & 25.6% & 12 & 0.0% & 8,180 & 22.8% \\
| Ward A8 | 33,615 & 12,314 & 36.6% & 0 & 0.0% & 8,890 & 26.5% \\
| Ward B12 | 53,544 & 19,027 & 35.5% & 0 & 0.0% & 5,548 & 10.4% \\
| Ward B14 | 37,013 & 7,655 & 20.7% & 0 & 0.0% & 4,738 & 12.8% \\
| Ward B18 | 35,104 & 10,060 & 28.3% & 0 & 0.0% & 4,874 & 13.7% \\
| Ward B19 | 35,104 & 9,440 & 26.9% & 0 & 0.0% & 4,104 & 11.7% \\
| Ward C22 | 31,947 & 12,420 & 38.9% & 0 & 0.0% & 4,133 & 12.9% \\
| Discharge Suite | 9,180 & 0 & 0.0% & 0 & 0.0% & 0 & 0.0% \\
| Endoscopy Unit | 25,368 & 5 & 0.0% & 0 & 0.0% & 0 & 0.0% \\
| **Total** | 419,940 & 108,207 & 25.8% & 12 & 0.0% & 57,059 & 13.6% \\

There is high use of bank nursing assistants in many of the wards at Warrington Hospital. Many wards also have high proportion of hours left unfilled with wards seven and eight both having over 20% hours left unfilled.

The trust reports that it “continues to strive to reduce bank and agency reliance for all services. Non-qualified nurse agency spend is almost non-existent and bank usage is tackled through our recruitment drives to fill our vacancies.”

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)
Medical staffing
Planned vs actual

The trust has reported their medical staffing numbers below, by ward from April 2017 to March 2018 and from April to November 2018 in medicine at Warrington Hospital. The service had a fill rate of 47.7% from April 2017 to March 2018 which increased to 52.3% from April to November 2018.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Acute cardiac care unit - Ward A3</td>
<td>13.1</td>
<td>10.7</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>24.1</td>
<td>13.0</td>
</tr>
<tr>
<td>Ward A1 (AMU)</td>
<td>7.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Ward A2</td>
<td>26.6</td>
<td>8.0</td>
</tr>
<tr>
<td>Ward A4</td>
<td>12.6</td>
<td>8.7</td>
</tr>
<tr>
<td>Ward A7</td>
<td>13.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Ward B18</td>
<td>30.2</td>
<td>10.4</td>
</tr>
<tr>
<td>Total</td>
<td>127.2</td>
<td>60.7</td>
</tr>
</tbody>
</table>

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

Medical staffing levels were sufficient to provide safe care and treatment for patients. Doctors were based in medical wards and were available Monday to Friday. Doctors reviewed patients in daily ward rounds and were readily available to review any patients requiring their attendance at other times during the day. Nursing staff also had access to medical staff when they needed any particular advice about a patient and said doctors responded promptly.

We saw medical staff were present and accessible on most wards we visited during inspection. Doctors were available to see patients at weekends and at other times during the day or night, responding via the hospital bleep system.

Patient records we checked showed a doctor had reviewed them within twelve hours of having been accepted to the ward. We saw there was a consultant review within 24 hours after admission. Robust systems were in place for reviewing any medical patients who were admitted to non-medical wards as outliers. On one day of the inspection there was a total of 13 medical outliers. In all cases we saw that these patients had been seen, and case notes documented by a medical consultant, on the date we checked these.

Senior medical staff were available to support junior doctors when advice and direction was needed. We did not hear or see any issues of concern, or delays in accessing timely medical advice for patients. Doctors told us they had really good support from senior colleagues and there was good communication.

The service used long-term agency and locum medical staff to provide continuity in the medical rota and to cover any medical vacancies. This had included recruitment of doctors as foundation year three (FY3) bank staff. There was an ongoing action plan for recruitment to medical staff at different grades and specialisms, including consideration of alternative roles, such as physicians’ associates.
Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust provided information about their medical staff vacancy rate in medicine although it was unclear what time period this was related to. The trust reported a 17.3% vacancy rate which is equivalent to 11.4 full time equivalent (FTE) staff.

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

Turnover rates

From December 2017 to November 2018, the trust reported a turnover rate of 16.8% in medicine. This is higher than the trust target of 13%.

- Warrington Hospital: 17.4%

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

Sickness rates

From December 2017 to November 2018, the trust reported a sickness rate of 2.8% in medicine. This is lower than the trust target of 4.3%.

- Warrington Hospital: 2.9%

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

Information provided by the trust following inspection confirmed a vacancy rate of 17.29% for medical and dental staffing within the clinical business units. This was equivalent to 11.39 whole time equivalent posts.

Bank and locum staff usage

Warrington Hospital

From December 2017 to November 2018, the trust reported 16,278 (7.0%) bank hours and 33,896 (14.7%) locum hours were filled by medical staff in medicine at Warrington Hospital. There were 3,016 (1.3%) hours that were left unfilled.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Site/ward</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Locum Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Acute cardiac care unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward A3</td>
<td>26,772</td>
<td>293</td>
<td>1.1%</td>
<td>1,866</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>40,035</td>
<td>333</td>
<td>0.8%</td>
<td>744</td>
</tr>
<tr>
<td>Ward A1 (AMU)</td>
<td>43,223</td>
<td>4,706</td>
<td>10.9%</td>
<td>3,968</td>
</tr>
<tr>
<td>Ward A2</td>
<td>24,608</td>
<td>1,753</td>
<td>7.1%</td>
<td>316</td>
</tr>
<tr>
<td>Ward A4</td>
<td>23,333</td>
<td>436</td>
<td>1.9%</td>
<td>470</td>
</tr>
<tr>
<td>Ward A7</td>
<td>24,544</td>
<td>260</td>
<td>1.1%</td>
<td>1,496</td>
</tr>
<tr>
<td>Ward B18</td>
<td>48,549</td>
<td>8,497</td>
<td>17.5%</td>
<td>25,035</td>
</tr>
<tr>
<td>Total</td>
<td>231,062</td>
<td>16,278</td>
<td>7.0%</td>
<td>33,896</td>
</tr>
</tbody>
</table>
Ward B18 had the highest bank (17.5% of available hours) and locum usage (51.6% of available hours) in medicine at Warrington Hospital.

The trust reported an additional 19,029 central bank hours worked which were not able to associate with a specific speciality.

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

Staffing skill mix

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

**Staffing skill mix for the 90 whole time equivalent staff working in medicine at Warrington and Halton Hospitals NHS Foundation Trust**

```
<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>44%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>23%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>35%</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 (Star) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce Statistics - Medical (October 2018))

Records

Staff kept appropriate records of care and treatment.

This was an improvement from the last inspection, where we found that patient records were not always stored securely. Also, we had found previously that patient records were not always complete or accurate.

The service used both electronic systems and paper-based records of patient care. Nursing risk assessments were completed electronically, and care plans documented in paper records. We checked different patient records during inspection, including nursing care plans, risk assessments and medical notes, and found these were clear and available for staff to refer to.

Patient records were stored securely in locked trolleys near to nurses’ stations in wards we visited. Staff could access electronic records and guidance documents via the trust intranet, with enough computer terminals available for this. On some wards, patient records were also kept securely at patients’ bedsides.

We reviewed documentation for patients who lacked capacity to consent, we saw that processes for recording best interests’ decisions were not always recorded consistently. We saw in one case
that discussions had been held with the patient’s family, but this was not documented on the capacity assessment, in the record of best interests’ decision or the DoLS application. The family discussions had taken place and the completed record regarding these were identified on the electronic patient record. In total out of 15 records we reviewed, we found occasional inconsistencies where a specific entry on a record had been noted electronically, but not made in the equivalent paper record. Overall, we saw the documentation for recording capacity assessment and DoLS application was to a good standard. The service monitored improvement these records through audit.

Medicines

The service prescribed, gave, and stored medicines well. Although not all medicines prescribed had a signature or appropriate code to indicate if the medicines had been administered and some medicines were not available.

Medicines were prescribed and administered appropriately for patients reviewed. The allergy status of patients was recorded; and venous thromboembolism (VTE) risk assessments were completed for majority of patients and medicine prescribed accordingly. Non-stock medicines were dispensed as patient own drugs (PODs) and stored within the POD locker by the bed.

Antimicrobial treatments were prescribed, however not all prescriptions had review or stop dates documented; the indication for the antibiotic was not always recorded.

A medicines reconciliation had been completed for some of the records reviewed. NICE guidelines recommend a medicines reconciliation is completed within 24 hours. The pharmacy department report the medicines reconciliation rate as 26-28%, which is well below the expected rate of 90%. There were no pharmacy staff available to complete reconciliations at the weekend, or outside normal pharmacy hours.

Not all medicines prescribed had a signature or appropriate code to indicate if the medicines had been administered. A number of medicines were not administered as the medicine was not available; this included an antibiotic. It was unclear from records whether a subsequent dose was administered or not following this and there was no indication of any potential harm to the patients concerned. Any medicine incidents were reported to the ward manager or senior nurse and escalated via the trust’s electronic incident report systems. Duty of candour was followed if any harm was caused to the patient.

Pharmacy staff provided a weekly medicine top up service to the wards; expiry dates were checked by the staff. There was no evidence of any out of date medicines. We checked a sample of medicines and found they were all within manufacturers’ expiry dates.

Pharmacists attended daily board rounds to identify any patients who were due for discharge. This assisted in preparing the required medicines for patients to take home and helped avoid any delays for patients waiting for these.

Controlled drugs were stored separately with stock checks correctly recorded. Registers for controlled drugs had been signed by two staff members when these medicines had been dispensed. Nursing staff completed and recorded daily checks of controlled drugs and where we saw these, records of these checks were correct.

During inspection we saw on ward A8 there was no door to the treatment area, but all medicines and fluids were locked away and the medicines trolley was attached to the wall. We raised this to
the trust, who confirmed following inspection work had been completed and the room now had a door.

Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in fridges. This ensured medicines were safe and effective to be administered to patients. The trust had recently introduced a flow chart for checking fridge temperatures, to prompt staff to complete these. We also saw reference to the flow chart in a weekly email bulletin to staff on one ward. During inspection, when we checked this, we saw records were complete and up to date for daily fridge temperature checks.

We reviewed 11 medicine prescription charts in different wards. On AMU we saw four different medicines recorded as drug unavailable, one was an antibiotic with two doses missed. Another had four consecutive doses missed as drug not available. Related prescription charts were seen with missing signatures and or appropriate codes. On ward B12 for one medicine, we saw two doses recorded as drug unavailable on two separate days, with a dose in-between with no signature or code recorded.

Incidents

Never Events

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

From February 2018 to January 2019, the trust reported no incidents classified as never events for medicine.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 25 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from February 2018 to January 2019.

Of the 25 serious incidents 21 (84.0%) occurred at Warrington Hospital.

The types of incident reported at Warrington Hospital were:

- Slips/trips/falls meeting SI criteria with 13 (61.9% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with three (14.3% of total incidents).
- Pressure ulcer meeting SI criteria with two (9.5% of total incidents).
- Treatment delay meeting SI criteria with two (9.5% of total incidents).
- HCAI/Infection control incident meeting SI criteria with one (4.8% of total incidents).

(Source: Strategic Executive Information System (STEIS))

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.
and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Matrons and ward managers attended trust daily safety briefings, sharing immediate information about any risks and areas of concern. The full trust daily safety briefing was circulated by email to clinical staff, who also shared important learning from new incidents, or other relevant issues, in daily safety briefings on wards.

During inspection we observed a trust safety briefing, where information was shared about any outliers, any medicine safety alerts, incidents and any patient falls, ‘halt topics’ and ‘bright spots. A ‘hot topic’ was discussed, reinforcing the need to maintain checks of fridge temperatures for storage of medicine and referencing a flow chart document outlining correct procedures for this.

Ward managers also circulated details of any local incidents to staff on email updates; these were also discussed in ward safety briefings. We reviewed a weekly AMU update which identified trends from incident reporting and feedback; items identified included ‘incomplete handovers’ and ‘incomplete handovers prior to transfer’.

Staff had access to files and resources concerning incident reporting and shared learning via the local intranet. Managers also discussed outcomes of any serious incident reviews with staff during team meetings. Staff we spoke with during inspection were confident in using the incident reporting system and gave examples of when they had done this. We saw an incident of a patient fall during inspection, which was later reported on the trust’s system.

We saw there was a positive culture of incident reporting, particularly for low or no harm, and ‘near miss’ incidents. This reporting had improved since the last inspection and staff confirmed they received feedback whenever they had raised an incident.

Staff routinely raised an incident report in relation to patient safety. On the respiratory ward we saw evidence of incidents reported whenever there was a reduction in staffing level relating to patient acuity, or when patients with tracheostomies needed to be nursed in ward bays. Between 1 January 2019 and 10 March 2019 there had been six incidents of this type in total. We saw that mitigating actions were taken in response to the incidents raised, reducing the incident severity to a negligible level.

Serious incidents resulting in higher levels of harm were investigated through governance processes within the clinical business units. Any staff involved in more serious incidents were included in this process, in which managers, clinical leaders and others as relevant, were involved. We saw that a root cause analysis approach to investigation was followed, with systems in place for sharing learning following any serious incident investigations.

Senior medical and nursing staff participated in mortality reviews held within the clinical business unit, wherever there had been an unexpected or potentially avoidable death of a patient. Any learning, themes or trends noted from mortality reviews was shared with relevant staff. We heard of service improvements and examples of action taken as a result of serious incident investigation and mortality reviews, including a complete revision of the policy for telemetry and cardiac monitoring, and improved audit of this practice.

Staff we spoke with were aware of being open in communication with patients and carers regarding any errors which may occur during their treatment and care. Staff could explain situations where this might apply, such as a medicine error, or a delay in providing care, demonstrating their understanding of principles of openness and transparency.
Staff we spoke to knew of the statutory Duty of Candour principles and could provide an example of when this would need to be applied. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

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 27 new pressure ulcers, 18 falls with harm and 29 new urinary tract infections in patients with a catheter from January 2018 to January 2019 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers falls and catheter urinary tract infections at Warrington and Halton Hospitals NHS Foundation Trust

1 Total Pressure ulcers (27)
2 Total Falls (18)
3 Total CUTIs (29)

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
The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service. Ward managers described how they had used data from safety thermometer to implement different initiatives to improve patient outcomes. Amongst these initiatives, staff on acute medical wards had introduced strict observation of two hourly turns for patients at risk of developing pressure sores. Alongside this, the housekeeper conducted a daily audit of mattresses, with ordering of individualised pressure relieving mattresses and where indicated, specialised mattresses for patients receiving end of life care. There had been no new pressure sores on the ward since December 2018 following this action. The service overall had also achieved a reduction in catheter acquired urinary tract infections, totalling three only during the year.
Is the service effective?

Evidence-based care and treatment

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

Care and treatment were based on national guidelines including National Institute for Health and Care Excellence guidelines. Guidelines, policies and standard operating procedures were reviewed and discussed during governance meetings.

The service had care pathways which staff followed for different conditions, including for conditions such as sepsis and acute kidney injury. Specialist services also had local care pathways, including a frailty pathway which identified patients with higher or more complex care needs.

One of the medical consultants had identified and implemented a local pathway of care for patients with chronic kidney disease. We saw adherence to fluid balance monitoring was rigorously maintained for patients where any risks were identified.

Specialist nurses on the cardiac care unit followed a cardiac telemetry monitoring policy and flow chart, in order to assess and interpret patients’ heart rhythms in other parts of the hospital.

Nutrition and hydration

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

Staff assessed and monitored patients’ nutrition and hydration needs during their admission. Patients we spoke with said they had access to food and drink on request and generally described the food as good. We saw patients had water jugs at their bedside and staff checked these frequently, providing support to eat and drink where this was needed. There was a choice of meals available for patients.

Nursing staff monitored patients’ fluid intake. Staff encouraged patients to drink water and completed fluid balance charts for patients where closer monitoring was needed. During ward handover, we heard fluid balance charts were discussed and any concerns shared.

In one ward area we were told about a quality improvement project called ‘operation hydration’. This approach had been implemented, to support patients to be well hydrated, according to their individual needs. In this, patients were provided with a laminated drinks menu, with pictures of tea, coffee, juice and water for them to choose a drink from. Nurses took a trolley round six times during the day, in addition to regular meal and drinks times. A learning corner had been set up in the staff room, providing staff with further information and resources about hydration and wellbeing in patient care.

Nursing staff completed a malnutrition universal screening tool where patients were identified at risk of malnutrition. Records we reviewed showed these were monitored and appropriate actions implemented where needed.

A specialist nutrition and dietetics team were available to provide advice and nutritional support for patients when this was indicated. The team had participated in the global hydration and nutrition
week, the week prior to inspection; teams visited different wards to promote the importance of patients receiving the right nutrition during and after their hospital stay.

Speech and language therapists undertook swallowing assessments for patients and care plans were provided for patients who required assisted feeding and percutaneous endoscopic gastroscopy (PEG) tube feeding.

Patients transferred from wards to the discharge lounge continued to be provided with drinks and meals, including breakfast, lunch or evening meal, whilst waiting to leave hospital.

**Pain relief**

Staff monitored and managed patients’ pain levels, responding promptly to patients’ requests for analgesia.

Nursing staff assessed patients’ pain levels. Since the introduction of NEWS2 it was identified that the proforma for national early warning scores did not accommodate recording of pain scores as part of NEWS2 documentation. Nurses were keeping a separate paper record of this at the time of inspection whilst the pain team were working to resolve the documentation issue.

Nurses used the Abbey pain scale to monitor patients’ pain levels, where patients lacked the ability to articulate this for themselves. This would include patients such as those living with dementia, Alzheimer’s disease, or other cognitive impairments.

We saw that staff checked patients’ comfort levels periodically throughout the day, during which patients were asked about their general pain level or if they needed any analgesia.

Pain relief, including paracetamol and ibuprofen, was available for patients if they needed this. Patients said nurses responded promptly to requests for any pain relief. One patient on the stroke ward told us staff didn’t just give out pain relief all the time when patients wanted it but would always complete an assessment for this need.

Specialist advice was available from the trust’s pain team, for patients who presented with more complex pain and conditions.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

From September 2017 to August 2018, patients at the trust had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

- Patients in gastroenterology had a similar to expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in general medicine had a higher than expected risk of readmission for elective admissions
Non-Elective Admissions – Trust Level

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in endocrinology had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a similar to expected risk of readmission for non-elective admissions

Warrington Hospital

From September 2017 to August 2018, patients at Warrington 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 - Warrington Hospital

- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in cardiology had a lower than expected risk of readmission for elective admissions
- Patients in general medicine had a much higher than expected risk of readmission for elective admissions
Non-Elective Admissions - Warrington Hospital

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in endocrinology had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric 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 site based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (September 2017 - August 2018))

Sentinel Stroke National Audit Programme (SSNAP)

Warrington Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved an overall grade D in latest audit, July 2018 to September 2018 although it has performed well in terms of case ascertainment.

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Aug 17 - Nov 17</th>
<th>Dec 17 - Mar 18</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>B↑</td>
<td>A↑</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>

- Domain 2: Stroke unit has been grade E in terms of patient and team centred performance for the latest four quarters of data.
- Domain 3: Thrombolysis has seen a decline in patient centred performance in the latest audit (grade E) compared to the previous audit (grade C). It has been level E in team centred performance for latest two quarters.
- Domain 4: specialist assessments has been grade E in terms of patient and team centred performance for the latest four quarters of data.
- Domain 8: Multi-disciplinary team working has seen a decline in patient centred performance in the latest audit (level C) compared to the previous audit (level D) and a decline in team centred performance from level D to level E.

Positively:
- Domain 5: Occupational therapy has been grade A in terms of patient and team centred performance for the latest four quarters of data.
- Domain 9: Standards by discharge has seen an improvement in patient centred performance in the latest audit (level B) compared to the previous audit (level C).
- Domain 10: Discharge process has been grade A in terms of patient and team centred performance for the latest four quarters of data.
Patient centred performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Aug 17 - Nov 17</th>
<th>Dec 17 - Mar 18</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>C↑</td>
<td>C</td>
<td>D↓</td>
<td>D</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>C</td>
<td>D↓</td>
<td>C↑</td>
<td>E↓↓</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>B</td>
<td>C↓</td>
<td>C</td>
<td>D↓</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Patient-centred total key indicator level</td>
<td>C↑</td>
<td>D↓</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>

Team centred performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Aug 17 - Nov 17</th>
<th>Dec 17 - Mar 18</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>C↑↑</td>
<td>D↑</td>
<td>E↓</td>
<td>E</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>NA</td>
<td>NA</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>D</td>
<td>C↑</td>
<td>D↓</td>
<td>E↓</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Team-centred total key indicator level</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>

(Source: Royal College of Physicians London, SSNAP audit)

The service had an action plan in response to the SSNAP audit outcomes, identifying improvement actions relating to provision of speech and language therapy; and nutrition and swallow assessments. The service had been developing a collaborative model with a neighbouring NHS Trust, in which Warrington was being classified as a ‘non-routine admissions ward’. It was anticipated that with transfer of the hyper-acute stroke services from 1 April 2019, the trust’s audit scores would improve.

Lung Cancer Audit 2017

The table below summarises Warrington and Halton NHS Foundation Trust’s performance in the 2017 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets 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>79.3%</td>
<td>N/A</td>
<td>Does not meet the audit aspirational standard</td>
</tr>
</tbody>
</table>
| Case-mix adjusted one-year survival rate  
(Adjusted scores take into account the differences in the case-mix of patients treated) | 35.0% | Within expected range | No current standard |
| 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) | 19.4% | Within expected range | ✓ |
| 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 to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen) | 64.6% | Within expected range | ✗ |
| 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) | 38.3% | Worse than expected | ✗ |

(Source: National Lung Cancer Audit 2017)
Audit results for the National Lung Cancer Audit 2018 showed the trust was an outlier in one parameter, for pathological confirmation in early stage lung cancer. This data was raised in a query to the National Cancer Registration and Analysis Service (NCRAS) data analysis team, who have advised that this was due to discrepancy in data collection. In all other parameters/KPIs the trust was either at par or doing better than national average. Therefore, no further action was required.

National Audit of Inpatient Falls 2017

The table below summarises Warrington 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>Meets national 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>X</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>16%</td>
<td>Red</td>
<td>X</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>8%</td>
<td>Red</td>
<td>X</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 good practice in falls prevention)</td>
<td>23%</td>
<td>Red</td>
<td>X</td>
</tr>
<tr>
<td>Crude proportion of patients with a call bell in reach (if applicable) (Having a call bell in reach is an important environmental factor that may impact on the risk of falls)</td>
<td>76%</td>
<td>Amber</td>
<td>X</td>
</tr>
</tbody>
</table>

(Source: National Audit of Inpatient Falls 2017)

**Chronic Obstructive Pulmonary Disease Audit**

The table below summarises Warrington Hospital’s performance in the 2018 Chronic Obstructive Pulmonary Disease Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets 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>67.5%</td>
<td>Better than the national aggregate</td>
<td>✓</td>
</tr>
<tr>
<td>Metrics (Audit measures)</td>
<td>Hospital performance</td>
<td>Audit’s Rating</td>
<td>Meets national standard?</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------</td>
<td>----------------</td>
<td>-------------------------</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>✓</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>47.1%</td>
<td>Better than the national aggregate</td>
<td>✓</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>100%</td>
<td>Better than the national aggregate</td>
<td>✓</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>53.7%</td>
<td>Better than the national aggregate</td>
<td>✓</td>
</tr>
</tbody>
</table>

(Source: Chronic Obstructive Pulmonary Disease Audit 2018)

National Audit of Dementia

The table below summarises Warrington 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>Meets 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 (A key aim of the audit was to collect feedback from carers to ask</td>
<td>100%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>Condition</td>
<td>Percentage</td>
<td>Improvement</td>
<td>Standard</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------</td>
<td>------------</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?”</td>
<td>91.2%</td>
<td>Better</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 (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)</td>
<td>88.0%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>Multi-disciplinary team involvement in discussion of discharge (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)</td>
<td>100%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Audit of Dementia 2017)

The stroke unit had previously established a “Warrington stroke categories” system to assist in identifying patients’ expected rehabilitation outcome and anticipated length of hospital stay. This helped facilitate more meaningful clinical discussions with families, plan services more effectively and to produce relevant clinical audit. Patients’ strokes symptoms would be assessed and graded on a scale of severity from one to six, with therapy support and care planning allocated in response to the grade scores. Numerous audits had demonstrated the ability to accurately predict the patient’s estimated date of discharge and the stroke unit has shown a reduced length of hospital stay from 47 to 34 days when compared with a similar cohort of patients and like for like service delivery. Further work on refining the categories and the discharge process within the unit led to a further reduction in length of hospital stay 25 days.
## Competent staff

### Appraisal rates

**Trust level**

The trust had a target of 85% of staff having an appraisal by the end of the financial year. From April 2018 to December 2018, 70.5% of staff within medical care at trust level received an appraisal.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Eligible staff</th>
<th>Completed appraisals</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical (ST&amp;T) staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>39</td>
<td>32</td>
<td>82.1%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>5</td>
<td>4</td>
<td>80.0%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>46</td>
<td>35</td>
<td>76.1%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>181</td>
<td>130</td>
<td>71.8%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>266</td>
<td>188</td>
<td>70.7%</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>43</td>
<td>21</td>
<td>48.8%</td>
</tr>
<tr>
<td>Public health &amp; community health services</td>
<td>2</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>583</strong></td>
<td><strong>411</strong></td>
<td><strong>70.5%</strong></td>
</tr>
</tbody>
</table>

Following the inspection, the trust provided us with the compliance at the end of the which showed that 91% of staff within medicine received an appraisal compared to a trust target of 85%. Qualified nursing staff met the trust target with a 90.1% appraisal rate. Medical staff had an appraisal rate of 100% which met the trust target. Other staff had a compliance of 90.3% which met the trust target.

**Warrington Hospital**

The trust had a target of 85% of staff having an appraisal by the end of the financial year. From April 2018 to December 2018, 71.4% of staff within medical care at Warrington Hospital received an appraisal.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Eligible staff</th>
<th>Completed appraisals</th>
<th>Appraisal rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical (ST&amp;T) staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>39</td>
<td>32</td>
<td>82.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>5</td>
<td>4</td>
<td>80.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>46</td>
<td>35</td>
<td>76.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>159</td>
<td>116</td>
<td>73.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>240</td>
<td>172</td>
<td>71.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; dental staff - Hospital</td>
<td>40</td>
<td>20</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Public health &amp; community health services</td>
<td>2</td>
<td>0</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
The trust did not provide appraisals rates at the end of the year by location.

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

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

Completion rates for appraisals were high in the service; following inspection the trust confirmed this as 96.4% for nursing staff.

Nursing staff completed competencies in practice of core nursing skills, including cannulation, administration of intravenous fluids and taking blood samples.

Experienced nursing staff supported newly qualified nurses whilst they completed their preceptorship, which incorporated a rotation to different acute medical wards. Student nurses were also supported in local wards during clinical placements. We spoke with one recently qualified nurse who had applied to work at the trust following a positive experience of their student placement. They described having very good support for their induction and preceptorship.

Individual members of nursing staff acted as champions for different areas of clinical practice, sharing expertise and best practice approaches with other clinicians. These areas covered a wide range of subject areas, including learning disability; safeguarding; continence; pain; palliative care; diabetes; infection prevention and control; sepsis; falls; resuscitation. All nursing staff completed a falls e-learning programme to raise awareness of the needs of patients at risk of falling.

The clinical business units supported development of advanced nurse practitioner roles, with five of these clinical staff working across the service at the time of inspection.

A local induction was available for bank and agency staff to ensure they were familiar with the ward environment and trust procedures. A band six nurse would go through the local induction checklist with the member of staff before they started their clinical role on the ward.

Staff in some wards described how they had been involved in the ‘Listening into Action’ programme in the trust to improvement their service. Through this programme, staff identified areas for change and were supported to lead development of these improvements. The acute medical admissions ward had implemented a midday “board round”, involving members of the multi-disciplinary team, to support patient discharge and assist in patient flow, as a result of this programme.

Junior doctors described being very well supported by consultants and senior medical staff, with bedside training and clinical review sessions. We observed a doctor teaching a medical student on cardiac management and interpretation of X-ray indications during the inspection. Doctors were encouraged to attend and present at weekly “grand rounds” learning sessions.

The clinical business unit had identified a bespoke leadership management programme to support medical consultants during their first two years in the role. This aspect was promoted and appeared successful in attracting recruitment.
Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Multidisciplinary team working was evident in routine day to day practice.

Communications between different members of the multidisciplinary team were focussed on patients’ needs during their admission. A wide range of different professionals, including clinical and non-clinical staff, liaised as was needed to plan and deliver the right treatment and care for patients. This extended to include co-ordination with external organisations and staff, to co-ordinate any continuing care. This included medical and nursing staff; different allied health professionals, such as physiotherapists, occupational therapists, speech and language therapists and dieticians; also, social workers and discharge co-ordinators.

On the medical assessment unit, a doctor to nurse communication sheet had recently been implemented. This identified any updates to nursing staff following morning ward rounds, with daily checklist of tasks or investigations needing to be completed for each patient. Nurses we spoke with said this system was working very well, although had not yet been fully evaluated.

Consultants or registrars led a daily board round, attended by all ward doctors; nurse co-ordinator; rapid response team; ward pharmacist; allied health professionals. Consultant-led multidisciplinary team meetings were held on various wards, including comprehensive case review and discharge planning for patients who required this. Discharge facilitators were available on wards to facilitate any planning for patients being discharged from wards, liaising with other community staff for arranging any follow-up. Social workers also participated in discharge planning for any patients, to provide for any identified social or community needs.

Ward staff had access to mental health liaison practitioners from a local trust when needing to provide support for any patients with a mental health need.

A cognitive assessment team was available to review any patients with a cognitive impairment, to determine the patient’s individual needs and suitability for transfer to the forget me not unit.

The recently opened frailty assessment unit incorporated a fully interdisciplinary team approach. In this, each individual clinician was being upskilled in different areas of practice, such that all team members would be able to conduct the equivalent level of assessment for patients. Managers and staff described this model as ‘real teamwork’ and patient feedback was extremely positive. The unit worked across pathways of care, into accident and emergency departments, GP services, with community matrons and acute medical units.

Dieticians were available to support patients as needed on all the medical wards. Staff told us the full dietician team on the cardiac care unit were a ‘huge presence’, offering individualised advice and information to patients about healthy eating and lifestyle, following a heart attack. Following discharge, the cardiac rehabilitation would contact the patient within seven days to discuss progress. A full cardiac rehabilitation programme was offered from six weeks after discharge.

Seven-day services

The frailty assessment unit was available over seven days, 8.30 am to 6pm.

Ward based therapy services were routinely available Monday to Friday, with on call response for urgent needs over weekend. Therapy services were also provided for any new patients admitted at weekends, who had potential to be discharged quickly with therapy support.
Health promotion

The “#endPJparalysis” initiative was promoted in elderly care wards and the stroke ward to promote patients' well-being and recovery.

In cardiology, a consultant had introduced a “smart heart” health promotion programme in local schools. This focused on educating children about the dangers of smoking. One doctor who had been involved told us that following this programme, it was reported that some of the parents of children involved in the programme had chosen to stop smoking as a result.

Know you blood pressure” stands and information about stroke support services was available on the stroke unit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that from April 2018 to December 2018, Mental Capacity Act (MCA) training was completed by 98.7% of staff in medicine at Warrington Hospital compared to the trust target of 85%. Both medical staff and qualified nursing and health visiting staff had a completion rate of 100% each.

Over the same period Deprivation of Liberty Safeguards training was completed by 74.0% of staff in medicine at Warrington Hospital compared to the trust target of 85%. Qualified nursing and health visiting staff had a completion rate of 64.9% and medical staff had a completion rate of 76.6%.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Extensive action has been implemented in the trust in relation to Mental Capacity Act and Deprivation of Liberty Safeguards following the last inspection and we saw this area was significantly improved. At the last inspection, general awareness of MCA and DoLS was low and procedures not well established. Actions since the last inspection had included trustwide training events, production of information booklets by staff, seven - minute briefing sheets, desktop reminders and MCA tenth anniversary information sheets. Solicitors had also visited the trust to raise awareness of MCA and DoLS for staff, incorporating sessions about suicide awareness and challenging behaviours.

We saw staff, including student nurses, had good awareness of consent and mental capacity issues, and the relevance of this for the type of patients seen in the service and the care provided. A best interest and mental capacity act checklist had been introduced and was being used on wards for patients who were living with dementia. This was seen in use during the inspection and the system appeared to work well. Appropriate documentation was completed for patients who lacked capacity, with capacity assessment and best interests’ decisions recorded where a DoLS had been applied. Where patients had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders, these were documented correctly and reviewed appropriately.

The safeguarding team held monthly meetings with the local authority regarding any applications deprivation of liberty safeguards. They routinely compared submissions to ensure that they were up to date and to check that all submissions made had been shared with the safeguarding team.
In 15 records we checked, we saw there were minor inconsistencies in documentation, where records of family discussions had been held, and noted on the electronic patient record, but not recorded on the related forms. We also found DoLS applications had been submitted to the local authority but as there was a requirement for local authority staff to visit the ward and authorise these, a number were now out of date due to staff being unable to attend these visits.

Audits had shown improvement in staff understanding of mental capacity assessment since the last inspection. Applications for Deprivation of Liberty Safeguards to the local authority indicated staff had improved recognition of restrictions and restrictive practices.

The safeguarding team provided bespoke mental capacity act training and deprivation of liberty safeguards, with high levels of compliance for this. Trust-wide data for completion of mental capacity act training was 97% of staff, for DoLS training 86% of staff.

### Is the service caring?

**Compassionate care**

**Friends and Family test performance**

From January 2018 to December 2018, the Friends and Family Test response rate for medicine at the trust was 27% which was better than the England average of 24%. Warrington Hospital had a response rate of 28%.

A breakdown by ward is shown below. There was a data issue in January 2018.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
<th>Annual perf</th>
</tr>
</thead>
<tbody>
<tr>
<td>END - DAYCARE - ENDOSCOPY UNIT W</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BNH - DAYCARE - ENDOSCOPY UNIT W</td>
<td>1,629</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>ABUJA - WARD 1A 1A - W W</td>
<td>1,341</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>WCSD - ASSESSMENT CARE CENTRE - W</td>
<td>392</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>CL - DAYCARE - CATHERET L1 - W</td>
<td>322</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>JH - WARD A7 - W</td>
<td>272</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>AA - WARD A5 - W</td>
<td>205</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>AS - WARD A6 - W</td>
<td>281</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>C11 - WARD D11 - T</td>
<td>169</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>A7 - WARD A7 - W</td>
<td>176</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>COU - CORONARY CARE UNIT COU - W</td>
<td>167</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>HE - WARD A5 - W</td>
<td>152</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
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<td>174</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>FRAGILTY ASSESSMENT UNIT - W</td>
<td>129</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>B14 - WARD B14 STRIKE UNIT - W</td>
<td>176</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>C02 - WARD C02 WINTER - W</td>
<td>101</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Highest score to lowest score**

**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.

The frailty assessment unit had the highest response rate with 62%, whilst ward A5 had the lowest response rate with 18%.

*(Source: NHS England Friends and Family Test)*

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
Staff were caring and showed kindness to patients during their hospital admission, respecting the dignity of patients and those who were close to them. Through their activities, staff demonstrated awareness of the “6 Cs” of care: compassion, courage, communication, commitment and competence. All staff in the multi-disciplinary team had a focus on patients’ individual needs and were sensitive to any changes in these. Staff considered the holistic needs of patients when delivering care; they engaged in clear and professional communication with patients, their families and carers.

Staff displayed a non-judgemental attitude when discussing or caring for patients who were living with dementia or who had a mental health need. They allowed time to respond to each patient individually and were attentive to patients who were anxious or distressed. Staff were seen to be busy, however they maintained a calm approach when interacting with patients and other members of staff. There was a settled and orderly atmosphere in the wards we visited, in which patients were supported to feel as comfortable as they were able to feel.

Patients’ privacy and dignity was attended to in an ongoing approach. Privacy signs were displayed on curtains surrounding patients’ beds, and curtains closed, whenever personal care or physical examinations were taking place. Staff spoke to patients sensitively and appropriately, with consideration for patients’ individual needs and lowering their voices to protect patients’ privacy when providing care. We heard ward staff asking patients’ permission before undertaking their personal care.

Ward bay doors were kept closed where possible to support patients’ privacy and minimise any disturbance from the activity of the ward. Wards displayed notices requesting staff and visitors to reduce activity and noise levels after 10pm, to allow patients to have a restful night’s sleep. Included here were reminders for nursing staff to wear soft soled shoes, to speak in quiet voices and prompts for turning volume down on mobile phones and televisions.

We observed staff interacting positively with patients and those close to them on the different medical wards we visited. Staff encouraged patients to be as independent as they could manage in self-care activities, such as eating, drinking and taking medicines. They provided appropriate support when this was needed.

At the time of inspection wards were preparing for mothers’ day celebrations, with decorations, banners and bunting. We saw on the forget me not ward a hairdresser had been arranged to style ladies’ hair for the occasion. We saw there was consideration of patients’ wider well-being and celebration of special days and events; on an elderly care ward a doctor had brought a television in for patients and relatives to watch a football match, at the same time another television was available for patients to watch the royal wedding.

We heard on one ward how a wedding had been arranged for a terminally ill patient on the ward. Staff described how they worked together to arrange food, bake cakes, provide decorations and cards, all arranged for within a very short space of time over 24 hours. All described how it was an overwhelming privilege and experience a to be able to fulfil this occasion for the patient and their family. We heard that the patient sadly died the following day but that their family were immensely grateful to staff that the wedding had been able to happen as the patient wished for.

Patients were happy with the care they received from staff and said they were treated well. Patients told us the staff were “friendly, polite and informative” and that personal care was “extremely good.” On the acute cardiac care unit, we heard from patients that care was “100% fantastic.”
**Emotional support**

Staff provided emotional support to patients to minimise their distress.

We observed staff attending to patients when they were distressed or appeared upset, taking time to sit with patients and speaking with them in a calm and reassuring way. Staff were aware of the different behavioural effects that having conditions such as dementia, or a terminal diagnosis, could have; they took note of and responded to patients’ changing behaviours.

Where patients were more vulnerable due to their confusion, frailty or medical condition, staff provided enhanced care in ward bays. Staff remained close to those patients who required higher levels of care or supervision and we saw staff actively checking and responding to individual patients during the day, aiding and comfort whenever this was needed.

We saw during inspection an unavoidable accident, where a patient fell whilst they were mobilising. A doctor was summoned for immediate medical review and nurses completed the required observations. Although the patient did not sustain any serious injury from the fall, we saw staff were attentive to the patient following this incident and provided reassurance and encouragement throughout the day.

Specialist staff were available, including nurse specialists, spiritual leaders and mental health liaison staff, to provide for patients’ emotional support needs. Psychological assessments and advice were available where this need was identified.

Attention was given to patients comfort when receiving care and treatment during a longer hospital admission, for example following a stroke. We saw patients had mementos on display from their homes in their room, including photographs of family or pets, and small ornaments.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment. Patients told us they were involved in decisions about their treatment. Patients said nurses and doctors explained their conditions, treatment and the investigations that may be necessary as part of their care. Staff introduced themselves and communicated clearly to ensure patients fully understood. Patients were encouraged to ask questions and were given time to assist their understanding.

We did hear isolated exceptions to this however, where one patient had felt they had to bring a friend in to try and find out what was going to happen in their plan of care. Another commented that although care was good, and staff were lovely, there was a lack of continuity with staff, which their relatives found slightly distressing.

Patients who lacked capacity to consent to decisions about their care and treatment and those close to them were involved in decisions about their care. Patients’ individual needs and preferences were communicated to staff by their relatives, and we saw these were recorded in care plans, although not always recorded in patients’ case notes.
Is the service responsive?

Service delivery to meet the needs of local people

Services were planned and provided to meet the needs of people.

The service recognised the needs of the local population and used various sources of information, such as public engagement and local statistical data to design and plan services. Services were reviewed and planned on the basis of this available information, which also included audit results and patient feedback.

The facilities and premises within the service were suitable for the patients receiving treatment and care. We saw that staff had a high awareness of the needs of people living with dementia, with a focus for the related environmental considerations for this in many areas.

The frailty assessment unit had been established in December 2018 as a non-substantive model; it was anticipated this would become a substantive service in 12 months. The unit had demonstrated an improvement in reducing admissions for patients presenting at accident and emergency department, but who did not require acute care. This was seen as particularly of benefit for patients who already had a community package of care in place, as any potential admission for these patients may have interrupted this continuing provision. The unit initially began as a test of the pathway from the accident and emergency department; this was now extended to include patients in the clinical decisions unit and acute medical units. The focus for further development was expansion of the service into the community, with the local authority community team already working as part of the model.

Meeting people’s individual needs

The service took account of patients’ individual needs and provided a patient-centred approach in providing care.

The service responded to people’s individual needs in different ways.

Staff were aware of the needs of patients who were living with dementia and we saw staff had a focus for this when assessing patients’ needs. The service had a forget me not unit, providing a dementia friendly environment and facilities for patients’ who required this. We saw that dementia friendly approaches were well established across the service, supported by dementia champions. The service used a ‘this is me’ form, as supported by the Alzheimer’s Society, for families to record information in. The form can include details of the person’s cultural and family background; events, people and places from their lives; preferences, routines and their personality.

A hospital communication book was used similarly for patients, on the stroke and elderly care wards, to share information about their needs and preferences. This contained a wide range of health information and related pictures or symbols. This assisted patients to indicate levels of comfort and happiness.

Language interpreters and translators were available when required, to support the needs of patients whose first language was not English. Most patient information leaflets we saw were in English, offering availability in other formats.

Dietary information was available for patients and alternative menus provided for patients from different cultural and religious backgrounds.
The trust had developed close links with advocacy services and staff would notify an independent mental capacity advisor (IMCA) when advocacy was needed for a patient lacking capacity. The trust had also identified that further advocacy training was required for staff and this was being arranged.

Patients who were identified with the highest level of enhanced care need from risk assessment, were provided with one-to-one care. Nursing staff wore yellow arm bands to indicate they needed to be present with the patient at all times; they would not be able to leave the ward bay until an immediate replacement member of staff was available. Patients were provided with yellow anti-slip socks which would also help alert staff to the need for monitoring any risk of falling.

Where there had been incidents of a patient fall, the service followed a falls pathway to document the relevant observations and investigations. This would include immediate response for any potential injury, fracture or bleeding; medical review and assessment prior to moving the patient; completion of an incident report; and information provided to relatives and carers concerning the fall. Where assessment identified this need, patients were referred for computerised axial tomography head scan or other X-ray investigations. Pain relief would be administered according to patient need.

Care plans were now being shared by local providers when patients with mental health concerns were sent to the hospital. These had helped to assist staff in managing patients’ needs during admission.

We observed a palliative care board in one ward area, with resources and information for staff and patients regarding palliative care needs of patients.

A wide array of information leaflets was available for patients in different areas, regarding various health conditions and services. Some that we saw included Frailty Assessment Unit – ‘A new way home’ – information for patients and their relatives; pressure ulcers, information for patients and relatives; and Information for you, your relatives and carers about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions; Patient Advice and Liaison Services. Information and directions to further resources was prominently displayed in the hospital. On the respiratory ward we saw information about tuberculosis, lung cancer. Asthma, breathlessness and chronic obstructive pulmonary disease was available.

Physiotherapists and occupational therapists delivered ‘morning movers’ sessions for patients on the cardiac care unit, and in some of the other medical wards. In this, patients were encouraged to be physically active as their condition allowed for, participating in exercise and movement, either from their bed or chair.

Staff on the forget me not ward supported patients to engage in creative activities, using the dining room for meals, activities, and socialising.

**Access and flow**

**Average length of stay**

**Trust Level**

From October 2017 to September 2018 the average length of stay for all medical elective patients at the trust was 6.2 days, which is similar to the England average of 5.9 days. For all medical non-elective patients, the average length of stay was 9.1 days, which is higher than the England average of 6.3 days.
Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology is higher than the England average.
- Average length of stay for elective patients in cardiology is higher than the England average.
- Average length of stay for elective patients in pain management is lower than the England average.

**Elective Average Length of Stay – Trust Level**

- **Gastroenterology**: This trust 6.2 days, England Average 5.9 days.
- **Cardiology**: This trust 5.2 days, England Average 4.6 days.
- **Pain management**: This trust 4.8 days, England Average 2.7 days.

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

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in endocrinology is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.

**Non-Elective Average Length of Stay – Trust Level**

- **General medicine**: This trust 9.2 days, England Average 6.3 days.
- **Endocrinology**: This trust 6.0 days, England Average 7.0 days.
- **Geriatric medicine**: This trust 5.0 days, England Average 9.4 days.

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

**Warrington Hospital**

From October 2017 to September 2018, the average length of stay for medical elective patients at Warrington Hospital was 7.3 days, which is higher than England average of 5.9 days. For medical non-elective patients, the average length of stay was 9.1 days, which is higher than England average of 6.3 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology is higher than the England average.
- Average length of stay for elective patients in cardiology is higher than the England average.
- Average length of stay for elective patients in respiratory medicine is higher than the England average.
Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in endocrinology is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.

(Source: Hospital Episode Statistics)

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

From December 2017 to November 2017, the trust's referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average. In the latest period, November 2018, the trust's performance was 89.7%, compared to 88.2% England average.
Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>100%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>96.9%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>95.6%</td>
<td>81.4%</td>
</tr>
</tbody>
</table>

Two 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>General Medicine</td>
<td>95.2%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>86.8%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

Patient moving wards per admission

The trust provided information on the wards which have the highest number of ward transfers (Ward A1 (AMU), Ward A2, Ward C21 and Ward B19 – all at Warrington).

For the above wards from December 2017 to November 2018, 70.4% of individuals did not move wards during their admission, and 29.6% moved once or more. This is similar when compared to the same period in the previous year where 73.1% of individuals did not move wards and 26.9% of individuals moved once or more.

Patient moving wards at night

From December 2017 to November 2018, there were 1,223 individuals moving wards at night within medicine. Ward A2 had the most with 420 (34.3%).

The frailty assessment unit had been established to limit hospital admission for patients whose medical needs were predominantly in relation to their frailty, rather than need for acute medical care. The service worked to identify any support that was needed to maintain patients’ functional ability at home, co-ordinating community and social services support as indicated from the patient’s assessment.

A therapy triage service was in development, in which therapists worked closely with the rapid response team to support improved patient flow. Senior therapists assessed or reviewed patients in their homes to determine any equipment or support needs, liaising with social services for ongoing provision as needed.

A new stroke pathway was imminently starting at the time of inspection, in which any patients initially diagnosed with or suspected of having a stroke, would be directed to a neighbouring NHS Trust. Here patients would receive initial thrombolysis and hyper-acute stroke services for the first
72 hours after a stroke, before returning to Warrington hospital for any continued care or rehabilitation.

The hospital had a discharge lounge for patients who were medically fit for discharge, with capacity for up to seventeen patients. Patients who were independent, or with minimal physical needs, could be admitted to the area. Two beds were available in this area, for patients who were less mobile but medially stable and who already had support in place, such as nursing home care.

Discharge facilitators were available on all medical wards to support patients medically fit for discharge or in discharge planning. We heard there could be some variation in the waiting times for discharge and integrated care facilities, depending upon whether the patient was resident in Warrington or Halton. A weekly length of stay meeting was held to discuss plans for any patients who had been admitted for more than 21 days, attended by a trust administrator, discharge facilitator, and representatives from community and social services. During inspection we saw the longest length of stay for a medically fit patient for an integrated care bed for was four weeks.

**Learning from complaints and concerns**

**Summary of complaints**

From December 2017 to December 2018, there were 83 complaints about medical care. The trust took an average of 40 working days to investigate and close complaints. The trust’s complaints policy states complaints should be completed and closed within 30 working days for moderate and low graded complaints and within 60 working days for high graded complaints. The vast majority of complaints are moderate and low grade.

Of the 83 complaints, 76 (91.6%) complaints were about Warrington Hospital. The most common theme was patient care with 60 complaints (78.9%), followed by communications with seven complaints (9.2%).

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

**Number of compliments made to the trust**

From January 2018 to December 2018, there were 200 compliments within medicine at Warrington Hospital the majority of these related to audiology.

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

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

All staff we spoke with described how they would initially try and resolve any complaints locally. At ward level and there were low numbers of complaints. Patients we spoke with informed us they were aware of how to raise a complaint and we saw information was displayed for patients and relatives regarding complaints processes.

Matrons told us numbers of complaints were reducing generally. Complaints were investigated thoroughly following trust procedures and met timescales for response. Patients were invited to
meet with ward managers and matrons to discuss any issues as part of the approach to respond to complaints.

We reviewed comments displayed on “you said we did” notices onwards. In one example, a patient comment stated they were told numerous times they would be seen by a physiotherapist, but one never came. The response stated there had been increased communication between nursing and multidisciplinary team staff on patient handover, to ensure important information was shared.

Although these were not formally documented, we saw many thank you notes displayed in the ward areas we visited, expressing positive and appreciative remarks about the care they or their relative had received.
Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Leaders were confident and knowledgeable about their services, providing support and direction for continuing development.

We saw that leadership was established and clear at all levels, within the medical services we inspected. Senior medical and nursing staff described a sense of great optimism and involvement from all staff, with a feeling of shared leadership. This view was similarly reflected by more junior members of staff and equally across services; it was a commonly expressed view that leadership overall had developed and improved since the last inspection.

Development opportunities were available for different roles and during inspection we spoke with several nursing staff being supported towards more senior positions. Staff said they felt supported to develop their confidence and experience in new directions, and extend their leadership skills. Leadership development programmes had been introduced for band seven nurses; ward manager leadership development, also a matron development course was being identified. Opportunities for coaching were also available to staff. A number of nurses we spoke with said there had been some real investment in the nursing workforce since the chief nurse had come into post.

We heard that senior leaders were visible and approachable in the service; with only isolated reports to the contrary heard from some we spoke with. The consistent message was that managers, leaders and executives were regularly involved and seeking to engage with staff in the service.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The trust’s corporate vision was to provide high quality, safe integrated healthcare to all our patients every day. The trust had identified a set of values, which were used in corporate communications and for staff to focus on in aspects of their daily activity. We saw the values were prominently displayed in the hospital, wards and clinical areas, as well as on the trust’s intranet. Staff said the values had meaning for them in their work and we saw in practice the values were well embedded. Staff personal development reviews were aligned to trust values.

The trust had a dementia strategy, due for revision in 2019, and a nursing and midwifery strategy 2017-2020. The title of the nursing strategy was “We think, we care, we listen, we see”. We saw the aspirations of the various trust strategies were relevant and integrated to everyday practice and care for staff.

Whilst clinical business unit leaders did not share a documented overall strategy, they were clear in articulating the vision for their services and worked closely together to achieve progress in this. Since the last inspection, there had been a major restructure of clinical business units in October 2018, with a ‘journey’ of bringing teams together in new structures, and a working group in place to identify and progress strategy development. Clinical business unit leaders identified key achievements since the last inspection as the establishment of seven-day services in cardiology; the combining of previously separate units into an acute cardiac care unit, with increased
establishment of staffing including consultant staffing for this; and establishment of the frailty service. Funding from NHS strategic transformation programmes had enabled development of the frailty pathway, with positive patient outcomes and 90% of patients discharged to their same place of residence after attendance. There was a focus towards a pathway approach for the future development of services, with a testing phase for an integrated care model, incorporating links with community services. This was already in place to some extent, with discharge planning and co-ordinators to facilitate patient flow. The future intention was to widen this approach, working across disciplines and together with system partners in social care and community services. Leaders considered innovative approaches in service design and achieving improved outcomes for patients.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

There was an open and transparent culture within the service. Without exception, all staff we spoke with had a positive and aspirational attitude towards their work, the service and the trust overall. Whilst staff acknowledged there had been challenges with staffing levels in some areas, they commented on this in a professional way, without expressing any negativity, or any potential impact on their own experiences from this. All staff were completely focussed on the needs of patients, their relatives or carers, and morale was extremely high. There was a strong sense of a ‘can-do’ approach in the service, and of working together as a team towards further improvement.

Staff of all grades consistently described feeling supported for their work and that they felt valued by the trust. Staff supported each other and said they shared positive and encouraging relationships as a team; we saw this was apparent during inspection. There was a collaborative approach to decision making, and where this involved patients and their careers, staff ensured patients were as fully enabled to participate and lead this process as they were able to.

Staff told us they were able to raise issues of concern to managers, without fear of retribution. They had confidence that managers would be supportive and respond to the issues raised, as was needed. We did not hear of any specific examples of when staff had done this; it was clear from staff that identifying and sharing issues was a part of the day to day communications and that any concerns were automatically responded to, as part of routine information sharing. We saw staff at all levels demonstrated respect for each other as a matter of course, through their actions and communications.

Staff we spoke with were aware of the trust’s freedom to speak up guardian and the purpose of this role. Since 2016, all NHS trusts are required to have a freedom to speak up guardian to support staff and promote a culture of speaking up, in situations where they may have identified concerns. We did not hear of any concerns staff had needed to raise to the freedom to speak up guardian.

**Governance**

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
Governance arrangements within the clinical business units were clear and well communicated. Governance meetings within clinical specialities followed a standardised agenda and reporting system, with these reporting to the senior leadership team governance committee and trust board.

Senior medical, nursing staff and business managers, met in monthly senior management team meetings, to review governance dashboards across the clinical business units. Dashboards provided key information about the quality of care in services. Quality metrics, peer review systems and the ward accreditation scheme provided leadership teams with key information about performance in safety and quality, incidents and risk management.

In allied health professions, one of the therapists in the rehabilitation team was a lead for clinical governance alongside their clinical role. This had allowed a greater focus for improvement in the sentinel stroke national audit performance, with regards to multi-disciplinary teamworking.

Medical and nursing leaders attended clinical business unit patient safety and risk meetings, and trust mortality review meetings. Important information from these forums was shared with staff through team communications, safety briefings and bulletins.

All staff we spoke with were clear about their own roles and the line management reporting arrangements within the service. Staff followed trust procedures and were aware of how to seek direction when this was needed. They were able to state their contribution to the work of the service as a whole and understood their responsibilities.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Managers monitored service activities at clinical business unit meetings, with review of key performance indicators, ward accreditation and financial targets. Performance across all the CBUs was monitored through the trust operational board.

The clinical business units had appropriate systems in place to identify and monitor risks. Risk registers were used at clinical business unit, medical speciality and ward level to highlight any issues and the level of potential impact these may have.

Risk registers were reviewed and managed appropriately, with escalation of risks and a timely response when this was needed.

Senior clinical business unit leaders had good oversight of risks in services, able to state key risks and mitigating actions for these. Risks included lack of specialist nurse staffing resource for heart failure patients, cover was currently in place from an interim consultant in speciality; estates issues on respiratory ward, with increased attention to infection prevention and control, audit and environmental cleaning; funding and long-term sustainability of the frailty service, with establishment of initial 12 months’ funding in place and discussion with commissioners ongoing; recruitment of consultant for stroke service. Nurse staffing and medical staffing was also an identified risk although there had been a staffing review and considerable work progressed to respond to both of these areas.

**Information management**

Senior staff had access to the information they needed to monitor performance and to ensure there was sustained or improved standards of care in the service.
Managers identified actions for improvement from their review of performance data and outcomes. Clinical staff had access to patients’ investigation results and we did not hear any concerns regarding any delays in receiving these.

Medical services had access to a range of information at ward and clinical business unit level, including audits, performance dashboards, staffing figures, complaints and patient feedback. Leaders of the service used this information to understand, investigate and respond to issues that arose in the division.

Important information such as safety alerts, minutes of meetings and key messages were displayed on notice boards in staff areas to help keep staff up to date and aware of issues. Staff could access relevant information, such as policies and other guidance, by the trust’s intranet.

Following the establishment of the acute cardiac care unit, consultants told us of development plans to create an electronic storage system, to allow for retrospective review of patients’ previous ECG records. Requests for telemetry monitoring were now being made via electronic systems with more consistent procedures.

**Engagement**

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

For patients with a learning disability, Easy Read leaflets have been produced and these had been reviewed by service user groups. Focus groups and carers cafes have been introduced to support patients and carers.

A daily movement and activity programme had been introduced by nurses and therapists to help prevent any decline in patients’ functional ability during their stay. An article had been featured in the local newspaper to publicise the benefits of the programme and raise awareness of loss of strength and deconditioning during admission.

On a number of medical wards, we saw invitations to join a matron’s teatime. This was described as an opportunity for patients to speak with matron about any issues, or simply to meet with the matron. Nursing staff said that communication with patients and their relatives was ongoing and any issues were responded as they arose.

Events and activities were promoted for patients following a stroke; these included working with the local stroke association’s ‘step out for stroke’ initiative. Staff, patients and relatives could also participate in the ‘resolution run’ event, with opportunity for wheelchair and walking participants to join.

Nursing and medical staff we spoke with described how they had benefitted from support which was available following their involvement in serious patient safety incidents and cases of unexpected death. This included individual meetings with line managers, team reflection, and access to occupational health advice and counselling. Staff described their perception of the trust’s “no blame” culture, with regard to occurrence of incidents; that the outlook from managers was always supportive and for a positive opportunity to reflect and learn, in order to improve services further.

The trust engaged with staff in many different ways. One important aspect we saw was the awarding of staff badges in recognition of particular achievements. We saw many staff wearing these badges, which reflected the trust values and different themes, such as ‘embracing change’.
Staff at all levels had opportunity to nominate another colleague for a particular award and badges were distributed by the chief nurse. It was evident there was a real sense of pride for each award gained; we heard this reflected also from discussions we had with senior leaders in the clinical business units. Staff in different areas were positively engaged in supporting and promoting this initiative, one ward we visited had established a “nurse of the month” award, with the candidate receiving a mug filled with toiletries and small gifts.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

One of the cardiology consultants had developed a ‘smart heart’ programme, delivering awareness of heart health and the importance of diet and exercise to local primary school children in the area. Over 1,000 children had participated in this.

The frailty assessment unit had received an award from a national journal and the clinical lead nurse consultant for frailty had been invited as expert advisor to NHS England.

Awareness of needs and support for patients living with dementia was well embedded in practice. The environment and facilities in the cardiac care unit and frailty assessment unit were designed and developed based on dementia friendly approaches.

We saw there was a focus on quality improvement in services, with my staff able to discuss examples of their involvement in these initiatives. The trust had established a quality improvement academy, with staff available to support the development of different improvement programmes. An example of this was the “heel’s angels” programme, which had helped promote pressure care management and reduce the incidence of pressure ulcers for patients.

Nurses had access to external courses and development, including for mentorship and leadership training. We spoke with one nurse who was being supported in a secondment role, to pursue a special interest in tissue viability nursing care.

Nursing staff on the cardiac care unit completed an examination in advanced life support skills at a neighbouring NHS trust.

Training opportunities were promoted and supported across the service, including sponsored places at a local university for band four nurses. Trainee nurse associate roles were also available.
Facts and data about this service

The digestive diseases, musculoskeletal and specialist surgery clinical business units are responsible for the delivery of surgical services across the Warrington and Halton sites. These services include: General surgery - including upper gastro-intestinal (UGI), colorectal, thyroid, breast services, urology, ear nose and throat, ophthalmology, trauma and orthopaedics, oral surgery and orthodontics.

The Warrington site comprises of surgical and trauma and orthopaedics inpatient beds (wards A5, A6 and A9) and 10 ophthalmology day case trolleys.

All emergency surgery including trauma is undertaken on the Warrington site in dedicated theatres. The Warrington site comprises of one emergency theatre, one trauma theatre, five elective theatres and one recovery area.

(Source: Routine Provider Information Request (RPIR) – AC1. Context acute)

The trust had 25,628 surgical admissions from August 2017 to July 2018. Emergency admissions accounted for 6,581 (25.7%), 16,000 (62.4%) were day case, and the remaining 3,047 (11.9%) were elective.

(Source: Hospital Episode Statistics)

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We inspected all four wards, theatres and recovery areas, ophthalmology day care unit and the surgical assessment unit.

We spoke to 40 different members of staff, ranging from doctors and nurses, therapists, housekeepers, health care assistants, consultants and theatre specialists. We interviewed surgical leads from all three clinical business units.

We spoke to 20 patients in all the wards, and patients who were going into theatre.
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. Managers kept electronic records of staff compliance and printed out monthly to keep in the staff room. Staff could access their own records to check when training was due for renewal.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

Trust level

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - No renewal</td>
<td>9</td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>91</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>98</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>79</td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>92</td>
</tr>
<tr>
<td>NHS conflict resolution (England) - 3 years</td>
<td>81</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>89</td>
</tr>
<tr>
<td>Counter fraud - no renewal</td>
<td>75</td>
</tr>
<tr>
<td>Medicines management awareness - no renewal</td>
<td>35</td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>68</td>
</tr>
<tr>
<td>Moving and handling - level 1 - 3 years</td>
<td>15</td>
</tr>
<tr>
<td>Infection prevention and control - level 2 - 1 year</td>
<td>78</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - 3 years</td>
<td>55</td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>43</td>
</tr>
<tr>
<td>Infection prevention and control - level 1 - 3 years</td>
<td>6</td>
</tr>
<tr>
<td>Resus level 2</td>
<td>85</td>
</tr>
</tbody>
</table>
In surgery the 85% target was met for 13 of the 16 mandatory training modules for which qualified nursing staff were eligible.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention and control - level 1 - 3 years</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>50</td>
<td>98.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>42</td>
<td>97.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>42</td>
<td>97.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>38</td>
<td>97.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - 3 years</td>
<td>22</td>
<td>95.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>15</td>
<td>93.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Counter fraud - No renewal</td>
<td>47</td>
<td>92.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS conflict resolution (England) - 3 years</td>
<td>31</td>
<td>91.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>39</td>
<td>90.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>39</td>
<td>90.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - No renewal</td>
<td>17</td>
<td>89.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control - level 2 - 1 year</td>
<td>30</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 1 - 3 years</td>
<td>22</td>
<td>84.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus level 2</td>
<td>32</td>
<td>84.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management awareness - No renewal</td>
<td>31</td>
<td>79.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 85% target was met for 13 of the 16 mandatory training modules for which medical staff were eligible.

Warrington Hospital surgery department

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 for qualified nursing staff in the surgery department at Warrington Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls Awareness &amp; Post Falls Pathway - No Renewal</td>
<td>9</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - Level 1 - No Specified Renewal</td>
<td>66</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>75</td>
<td>98.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness - No Renewal</td>
<td>47</td>
<td>95.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
At Warrington Hospital surgery department, the 85% target was met for 13 of the 16 mandatory training modules for which qualified nursing staff were eligible between April 2018 and December 2018.

The trust told us that at the time of the inspection compliance rates were above the trust target of 85% for every module (April 2019).

The trust reported that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. This means that the trust was unable to break down the mandatory training data for medical staff for Warrington and Halton Hospitals.

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 for medical staff in the surgery department at Warrington and Halton Hospitals is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Counter fraud - No renewal</td>
<td>35</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>35</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>23</td>
</tr>
<tr>
<td>Infection prevention and control - level 1 - 3 years</td>
<td>3</td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>23</td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>22</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - 3 years</td>
<td>22</td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>15</td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>21</td>
</tr>
</tbody>
</table>
At Warrington Hospital surgery department, the 85% target was met for 13 of the 16 mandatory training modules for which medical staff were eligible between April 2018 and December 2018.

The trust told us that at the time of the inspection compliance rates were above the trust target of 85% for every module (April 2019).

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.

We spoke to different levels of staff who described how they would raise a safeguarding concern; there was information available for staff electronically and in paper form.

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 at trust level for qualified nursing staff in surgery is shown below:
In surgery the 85% target was met for five of the six safeguarding training modules for which qualified nursing staff were eligible.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Safeguarding children - level 3 - 3 years</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>34</td>
<td>37</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>35</td>
<td>39</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>32</td>
<td>37</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>28</td>
<td>33</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>23</td>
<td>33</td>
</tr>
</tbody>
</table>

In surgery the 85% target was met for five of the seven safeguarding training modules for which medical staff were eligible.

**Warrington Hospital surgery department**

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 for qualified nursing staff in the surgery department at Warrington Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>48</td>
<td>49</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>62</td>
<td>65</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>46</td>
<td>52</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>34</td>
<td>40</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>30</td>
<td>40</td>
</tr>
</tbody>
</table>

At Warrington Hospital surgery department, the 85% target was met for five of the six safeguarding training modules for which qualified nursing staff were eligible. The trust told us that compliance rates were now above their target of 85% (April 2019).

The trust reported that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. This meant that the trust is unable to break down the safeguarding training data for medical staff for Warrington and Halton Hospitals.
A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 for medical staff in the surgery department at Warrington and Halton Hospitals is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding children - level 3 - 3 years</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>20</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>21</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>19</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>15</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>13</td>
</tr>
</tbody>
</table>

At Warrington Hospital surgery department, the 85% target was met for five of the seven safeguarding training modules for which medical staff were eligible between April 2018 and December 2018. The trust told us that at the time of the inspection compliance rates were above the trust target of 85% for every module (April 2019).

The service had a trust wide safeguarding team which included the chief nurse who was the executive lead for safeguarding at the trust and a trust wide head of safeguarding. There were also designated lead doctors and safeguarding lead nurses for both vulnerable adults and children and young persons.

The safeguarding team was available during core hours for staff to contact should they have any safeguarding queries or concerns. Outside of these hours we were advised staff could contact on call managers who could then provide advice if required. Safeguarding link staff attended forums, where information was cascaded in both directions, this information fed into the main safeguarding committee along with briefings by the surgical clinical business units which highlighted issues, good practice and learning.

The service had deemed that clinical staff on the wards, in the operating theatres and in the theatre’s recovery areas were required to be trained to level two in the safeguarding of children and young people. However, as the service treated young people aged 16 and 17, intercollegiate guidance stated they should be trained to level three. Managers in the service stated they were currently considering the levels of training required by such staff in response to the guidance.

Each area had a safeguarding ‘champion’ or link nurse who could support staff with potential concerns. There was also a children’s ward on the Warrington hospital site which was accessible by telephone for advice at any time of the day or weekends. Following our inspection, we saw that the trust has started to implement level three training for such staff and we saw that training sessions with dates had been arranged. Information regarding the sessions was shared on the trust’s morning safety bulletin.
**Cleanliness, infection control and hygiene**

The service-controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The trust had an infection prevention and control team who provided training for staff and completed infection control audits. We looked at audits for the period October 2018 to March 2019 for theatres, specialist surgery, wards and the surgical assessment unit. Compliance was high overall; any issues were immediately reported to the estates department and resolved by the department manager and housekeepers. Examples of audits included hand hygiene, uniform and environmental.

We looked at a range of areas including the sluice, shower rooms and bays. All areas were visibly clean and tidy with posters describing cleaning techniques; all cleaning checklists were signed and dated. We observed domestic staff cleaning the ward areas. Curtains around beds were changed every two weeks or more often if required. We saw checklists that made sure curtains were checked and changed in line with the trust policy.

All wards had ample personal protective equipment to maintain hygiene. For example, hand gel at entrances and within wards, and aprons and gloves available for staff. There were sinks and soap available with signs describing handwashing techniques. We observed staff washing their hands after patient interaction and using the hand gel at regular intervals. Patients told us the department was always clean and they saw staff constantly washing their hands.

There were posters at various points in the hospital showing the ‘bare below the elbow in clinical areas’ trust policy and staff adhered to the policy.

Waste was separated, all bins were labelled, and rubbish was stored correctly. Clinical waste was placed in yellow clinical waste trucks on the corridor behind the theatres. We found all the trucks were locked and not over full.

The department adhered to trust policy and screened all patients for methicillin-resistant staphylococcus aureus, (MRSA, a strain of antibiotic-resistant bacteria) on admission. A swab was taken for any patients with a wound.

Patients were screened for carbapenemase-producing Enterobacteriaceae (CPE) as per trust policy and there were no cases reported for the period October 2018 to March 2019.

We saw information posters for visitors detailing how to reduce the spread of infection and contact numbers for the infection control team.

We checked the theatres and saw cleaning schedules were displayed and signed and dated. The department had an effective system to manage cleanliness; dirty items were place in a hatch at the back of the theatres and this was removed and placed in a locked unit. The unit was scanned and sent off site to clean and decontaminate equipment. Equipment was returned within 24 hours. Staff could request a quicker turnaround if required. This was an improvement since the last inspection.

Theatre equipment not in use displayed ‘I am clean’ stickers.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.
The environment was fit for purpose and designed to meet the needs of patients. There were enough toilet and bathing facilities with clear signs for male and female. The bays had clear signs to show male or female and highlighted that bays were single sex; there were ‘do not disturb’ signs on curtains.

Patients that required observation could use bays closer to the nursing station.

We looked at a range of equipment on all the surgical wards, day case unit and surgical assessment unit. This included the resuscitation trolleys, oxygen and observation machines. All items were clean and had up to date electrical tests. The resuscitation trolleys were checked daily and we saw all checks had been completed for the past two weeks (March 2019). All items were available and stored securely.

We checked equipment cupboards and found all stock was labelled correctly, items such as syringes were in date and all the packaging was intact.

The theatre area had a key coded implant room to store orthopaedic implants. We found the stock was checked regularly as per hospital policy.

Staff told us there were never shortages of equipment. Faulty equipment was reported to the estates department and problems were resolved quickly. We saw evidence of this recorded in a dedicated book in the ward office.

We saw that sharps bins were in use, labelled correctly, closed, and not over full.

Staff told us that some wards did not have moving and handling equipment, for example standing hoists and aids. This meant therapists borrowed equipment from other wards which sometimes was not available and caused delays to therapy. We found there was no booking system in place for equipment.

There was an anaesthetic room attached to each theatre and we found that all cupboards were locked. We checked anaesthetic machines and log books. The checklists were all completed as per policy which was an improvement following the last inspection. We checked a range of equipment in the theatre areas and found it to be in good working order; all equipment checked had stickers to indicate a recent service.

All intravenous tubes were stored in a locked room. The pack room (place to store sterilised theatre items prior to use) stored items in speciality order and the service had an effective system to manage stock.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

We found that care plans and risk assessments were completed within six hours of a patient’s admission to the ward. These included: falls risks assessments, skin integrity and nutrition and hydration. We checked 15 patient records and found they had been completed for all patients. Patients were provided with pressure relieving mattresses where needed.

Patients were assessed for how closely they should be observed on admission. For example, patients who were experiencing a detoxification or had cognitive difficulties could be observed on a one-to-one basis. We saw evidence of this happening for patients during the inspection.
We found doctors completed deep vein blood clot and bleeding risk assessments on admission and saw these completed in all records we checked. Records indicated the level of bleeding risk and actions taken to minimise, for example, prescribing compression stockings. A second check was made on the ward to ensure the risk assessment had been undertaken.

The trust had recently began using the national early warning score two, (NEWS2, a guide to quickly determine the degree of illness of a patient based on vital signs and the interventions of escalation needed). Staff told us the system worked well and staff knew to observe patients more frequently depending on the score. We reviewed a sample of 15 forms and found they had been filled in correctly for all patients.

A section of the NEWS2 form triggered the sepsis pathway and what medicines to prescribe. All wards and the recovery area had a sepsis box available to use which included pre-made bags of gasses, bloods and sterile bags. All nurses carried a card showing a bleep number to highlight a patient who was on the sepsis pathway. Ward A5 was identified as needing to improve training compliance rates for sepsis which staff felt was beneficial.

The service used the five steps to safer surgery, World Health Organisation surgical safety checklist. We observed four patients in theatre and staff adhered to the checklist for all four patients. Staff used an electronic checklist alongside recording on paper. We found staff completed documentation correctly for ‘sign in, time out, and sign out’. The forms included prompts for clinicians, in line with best practice. For example, if blood loss was more than 500mls, the surgeon was prompted to consider appropriate treatments. We reviewed three patient notes which were all completed as per guidance. The trust checked information from the electronic checklists daily and concerns were investigated. The trust told us surgery stopped if any gaps observed.

The trust set up a quality group to look at safe surgery improvements, for example avoiding repetitive questions and increase clinician engagement. The trust audited the surgical safety checklist monthly and had maintained full compliance levels for the period April 2018 to March 2019. The head of theatre services completed monthly walkabouts around the theatres to observe and give feedback to the theatre managers.

The department had a critical outreach and medical emergency team, and staff were aware of the trust escalation policy to contact the team if a patient deteriorated or scored above six in the NEWS2. The trust had close links with a local NHS acute hospital for complex patients. If a patient suffered a digestive bleed they would be transferred in a blue light ambulance. The service had a major haemorrhage and anaesthetic emergency policy; this was stored in a folder alongside other emergency equipment in the recovery area.

Staff had access to the orthopaedic medical emergency team via a fast bleep. Staff could also bleep the cardiac arrest team who were available 24 hours a day. In the surgical assessment unit, we found that emergency patients were accompanied to theatre by a nurse.

Blood was stored in a dedicated blood fridge next door to theatres should a patient need a blood transfusion.

Theatre staff completed the perioperative care pathway for patients going into surgery. Staff checked that all necessary risk assessments and other checks were made prior to surgery. The pathway included checklists for tasks during surgery, with space to make notes. The pathway included a theatre to recovery handover sheet, followed by a recovery to ward handover sheet to make sure the patient was stable.
The trust told us that five observation audits of the World Health Organisation surgical safety checklist were completed once per week, with feedback given to individuals. The audit was presented to the trust patient safety and effectiveness subcommittee.

In 2017-2018: average compliance across 12 months was 99.87%. In 2018-2019 (year to date): average compliance across 8 months was 99.97%, reflecting an improvement.

In theatres, the service made sure that a nurse trained in advanced life support was on every shift and this was highlighted on the theatre information board. This was an improvement following the last inspection.

All surgical wards and the surgical assessment unit held a safety huddle every morning which included: patient alerts, concerns, risk of falls, patients who were nil by mouth, mental capacity and discharge status. There was a ward meeting every Friday and staff received a ward update via electronic mail.

The trust held a daily safety briefing which we observed during the inspection. Key themes included the number of falls overnight, medical outliers and safety alerts. All staff were welcome to attend the meeting and raise issues. The ward-based safety huddles followed the trust huddle, so information could be cascaded to wards.

Staff in the surgical department completed training to assess acutely unwell patients. This included the deteriorating patient, basic life support and intermediate life support. Staff on the wards did not complete advanced life support training as they had access to emergency teams. Two staff in the surgical assessment unit were due to attend advanced life support training.

In the theatre department all staff completed advanced life support training. The recovery staff did not complete advanced life support training as they were supported closely by theatre staff.

### Nurse staffing

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

#### Planned vs actual

### Warrington Hospital

The trust has reported their nursing staffing numbers below, by ward, from April 2017 to March 2018 and from April to November 2018 in surgery at Warrington Hospital. The service had a fill rate of 92.3% from April 2017 to March 2018 which decreased to 87.7% in the latest period.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Intervventional Radiology</td>
<td>3.5</td>
<td>3.5</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>19.0</td>
<td>17.6</td>
</tr>
<tr>
<td>Surgical Assessment Unit</td>
<td>7.5</td>
<td>5.8</td>
</tr>
<tr>
<td>Theatres</td>
<td>46.0</td>
<td>43.5</td>
</tr>
<tr>
<td>Ward A5</td>
<td>18.9</td>
<td>17.6</td>
</tr>
<tr>
<td>Ward A6</td>
<td>20.7</td>
<td>17.1</td>
</tr>
<tr>
<td>Ward A9</td>
<td>20.6</td>
<td>20.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>136.2</strong></td>
<td><strong>125.7</strong></td>
</tr>
</tbody>
</table>
Vacancy rates

The trust told us there were 4.8% nursing vacancies, and no vacancies for health care assistants. There was an ongoing plan to recruit to the vacancies.

Turnover rates

From December 2017 to November 2018, the trust reported a turnover rate of 13.6% in surgery. This is slightly higher than the trust target of 13%. A breakdown by site can be found below.

- Warrington Hospital surgery department: 12.2%

Sickness rates

From December 2017 to November 2018, the trust reported a sickness rate of 6.5% in surgery. This is higher than the trust target of 4.3%. A breakdown by site can be found below.

- Warrington Hospital surgery department: 5.4%

Bank and agency staff usage

From December 2017 to November 2018, the trust reported 15,764 (6.2%) bank hours and 15,650 (6.1%) agency hours were filled by qualified nursing staff in surgery at Warrington Hospital. There were 10,803 hours (4.2%) that were left unfilled.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Surgical assessment unit</td>
<td>14,612</td>
<td>1,466</td>
<td>16</td>
<td>0.1%</td>
</tr>
<tr>
<td>Ward A5</td>
<td>37,195</td>
<td>2,665</td>
<td>5,747</td>
<td>15.5%</td>
</tr>
<tr>
<td>Ward A6</td>
<td>40,908</td>
<td>1,555</td>
<td>5,906</td>
<td>14.4%</td>
</tr>
<tr>
<td>Ward A9</td>
<td>43,842</td>
<td>865</td>
<td>2,767</td>
<td>6.3%</td>
</tr>
<tr>
<td>Interventional radiology</td>
<td>7,523</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>36,433</td>
<td>302</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Theatres</td>
<td>75,090</td>
<td>8,910</td>
<td>1,214</td>
<td>1.6%</td>
</tr>
<tr>
<td>Total</td>
<td>255,602</td>
<td>15,764</td>
<td>15,650</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

During the same period, the trust reported 28,025 (15.0%) bank hours and 226 (0.1%) agency hours were filled by nursing assistants in surgery at Warrington Hospital. There were 14,777 hours (7.9%) that were left unfilled.

A ward breakdown is shown below:
Ward/Unit | Total hours available | Bank usage | Agency usage | NOT filled by bank/agency usage
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Surgical Assessment Unit</td>
<td>7,634</td>
<td>384</td>
<td>5.0%</td>
<td>0</td>
</tr>
<tr>
<td>Ward A5</td>
<td>35,974</td>
<td>9,496</td>
<td>26.4%</td>
<td>0</td>
</tr>
<tr>
<td>Ward A6</td>
<td>35,314</td>
<td>7,779</td>
<td>22.0%</td>
<td>0</td>
</tr>
<tr>
<td>Ward A9</td>
<td>41,031</td>
<td>8,561</td>
<td>20.9%</td>
<td>0</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>24,066</td>
<td>453</td>
<td>1.9%</td>
<td>0</td>
</tr>
<tr>
<td>Theatres</td>
<td>43,038</td>
<td>1,352</td>
<td>3.1%</td>
<td>226</td>
</tr>
<tr>
<td>Total</td>
<td>187,057</td>
<td>28,025</td>
<td>15.0%</td>
<td>226</td>
</tr>
</tbody>
</table>

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

The trust used the safer staffing matrix to look at acuity on wards and arrange the correct skill mix. The matron visited the wards every morning to check staffing levels for that day and the following day. The matrix highlighted whether staffing levels were unsafe, and this was managed through different methods.

Following the previous inspection staffing levels had improved and the trust implemented a rolling recruitment programme. The trust used social media to advertise for staff. Staff on all wards felt that staffing levels were safe, and they would not have two new members of staff on the same shift. Ward managers told us they aimed for a band six nurse on every shift.

Handovers were completed by the nurse twice a day which looked at the reason for admission, treatment plan and mental health status.

Consultants completed ward rounds every morning and evening.

**Medical staffing**

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

**Planned vs actual**

The trust has reported their medical staffing numbers below, by ward, from April 2017 to March 2018 and from April to November 2018 in surgery at Warrington Hospital. The service had a fill rate of 66.5% from April 2017 to March 2018 which is like 65.3% fill rate reported in latest period.

Please note: The trust report that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. Where possible, the trust has associated the departments to services/wards but for theatre staff the trust has allocated to the Warrington site based on where most of work is completed.

<table>
<thead>
<tr>
<th>Ward/Unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>21.6</td>
<td>15.6</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>18.3</td>
<td>10.3</td>
</tr>
<tr>
<td>Theatres</td>
<td>97.5</td>
<td>65.5</td>
</tr>
<tr>
<td>Total</td>
<td>137.4</td>
<td>91.4</td>
</tr>
</tbody>
</table>
In theatres there was always one ‘anaesthetist of the day’ who dealt with any recovery issues. This was in line with Association of Anaesthetists of Great Britain and Ireland guidelines.

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

**Vacancy rates**

The trust told us three were 5.4% vacancies for medical (and dental) staff.

**Turnover rates**

From December 2017 to November 2018, the trust reported a turnover rate of 12.1% in surgery. This is lower than the trust target of 13%.

The trust report that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. Where possible, the trust has associated the departments to services/wards but in most cases the trust has allocated the site based on where most of work is completed. This means that the trust is unable to break down the turnover data for medical staff at Warrington and Halton Hospitals.

- Warrington/Halton Hospital surgery departments: 11.0%
- Cheshire and Merseyside Treatment Centre: 16.6%

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

**Sickness rates**

From December 2017 to November 2018, the trust reported a sickness rate of 0.9% in surgery. This is lower than the trust target of 4.3%.

The trust report that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. Where possible, the trust has associated the departments to services/wards but in most cases the trust has allocated the site based on where most of work is completed. This means that the trust is unable to break down the sickness data for medical staff at Warrington and Halton Hospitals.

- Warrington/Halton Hospital surgery departments: 1.0%
- Cheshire and Merseyside Treatment Centre: 0.6%

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

**Bank and locum staff usage**

From December 2017 to November 2018, the trust reported 15,696 (6.0%) bank hours and 5,737 (2.2%) locum hours were filled by medical staff in surgery at Warrington Hospital. There were 312 (0.1%) hours that were left unfilled by medical staff.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Site/ward</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Locum Usage</th>
<th>NOT filled by bank or locum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Service</td>
<td>Volume</td>
<td>UCP</td>
<td>%</td>
<td>Zero</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------</td>
<td>-----</td>
<td>---</td>
<td>-------</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>46,936</td>
<td>63</td>
<td>0.1%</td>
<td>0</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>33,644</td>
<td>3,542</td>
<td>10.5%</td>
<td>539</td>
</tr>
<tr>
<td>Theatres</td>
<td>180,161</td>
<td>12,091</td>
<td>6.7%</td>
<td>5,198</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>260,741</strong></td>
<td><strong>15,696</strong></td>
<td><strong>6.0%</strong></td>
<td><strong>5,737</strong></td>
</tr>
</tbody>
</table>

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

**Staffing skill mix**

In October 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was higher. This trust had a higher proportion of middle career medical staff and lower proportion of registrar group than the England average.

**Staffing skill mix for the whole-time equivalent staff working at Warrington and Halton Hospitals NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>47%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>19%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>17%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>16%</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 (Star) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

**Records**

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

The surgical department used a mixture of paper and electronic record keeping. The computers were locked when not in use and staff were required to use individual identity cards to log in to the electronic system. The record included a flag to alert staff to issues such as diabetes and cancer pathway however it did not highlight safeguarding issues or Deprivation of Liberty Safeguards status. Staff told us this information was always discussed during the daily briefings.

All electronic records we checked contained up to date care plans and risk assessments such as diabetes, continence, moving and handling; they were updated once a week. All electronic records were dated and clearly showed names and roles of the staff who completed a care record.
Electronic records included information about patient discharge and this was automatically sent to the GP for patients who lived in Warrington and Halton. Information was sent via post for patients who lived outside of the area.

The paper records were stored in locked cupboards. We found that all paper records checked included the pre-operative and post-operative assessment, antibiotic information and discharge information. Records included mental capacity assessments and Deprivation of Liberty Safeguards authorisation requests where applicable.

Records included health passports where patients had undertaken a mental health assessment. The passports allowed staff to understand patient’s individual needs easily.

Paper records included a patient assessment and care planning booklet. This had sections such as pressure sores and dementia and mental health screening. We found that the booklets were not always filled in consistently. Staff told us this was because not all sections may be applicable to the patient and that information was recorded in other ways described above.

Ward A9 completed the fractured hip pathway. We checked three and found that the cognitive impairment and dementia assessment had not been completed. We highlighted this to the doctor who agreed they should be completed for all patients.

At the end of patient beds, a small paper folder contained records about fluid balance charts, nutrition (malnutrition universal screening tool), and comfort bundles checking subjects such as pressure areas and pain levels.

**Medicines**

The service had systems to prescribe, give, record and store medicines. The service made sure medicines management training was in place and medicines incidents were discussed at the ward safety briefing.

Medicines were prescribed and administered properly for most patients reviewed. The allergy status of patients was recorded; antimicrobial treatments were prescribed, however, not all prescriptions had review or stop dates documented and the indication for the antibiotic was not always recorded.

Venous thromboembolism (blood clot) risk assessments were completed and medicine prescribed accordingly.

Pharmacy staff provided a weekly medicine top up service to the wards; expiry dates were checked by the staff. There was no evidence of any out of date medicines. Staff recorded the date opened for medicines with a short expiry date.

The dose and time of ‘as required’ medicines were recorded.

The medicines fridge was monitored and we found temperatures were in the correct range. Nursing staff described correct processes for managing out of range temperatures.

Pharmacy technicians administered medicines to patients on selected wards under nurse supervision; this supported nursing staff to spend time on other tasks. Pharmacy technicians could support and counsel patients regarding their medicines and supported staff with the management of medicines. However, pharmacy technicians did not always counsel patients meaning there could be missed opportunities to provide additional information about medicines.
Medicines were stored securely and regular checks were performed to ensure controlled drug stock levels were correct. In the theatre and recovery areas, controlled drugs were stored securely and the controlled drug book was completed and checked twice a day as per trust policy.

Staff accessed medicines out of hours via the site manager, and there was access to the on-call pharmacist out of hours. The service had an electronic system to locate and access medicines from other wards.

Pharmacy staff completed controlled drugs audits, storage audits and prescription chart audits every six months.

We found that no patients managed their own medicines during their admission.

We found that one patient missed three doses of antibiotics. The notes stated this was due to the unavailability of a drug, although the pharmacy technician advised the drug was available in the fridge. We highlighted this to the ward manager.

Sepsis bags were stored in the treatment room and did not contain any medicines. However, they contained blood culture bottles that had expired. There was no system in place to monitor the expiry date of the bags.

A medicines reconciliation had been completed for seven out of nine records reviewed. The pharmacy department reported the medicines reconciliation rate as 26-28%, below the expected rate of 90%. There were no pharmacy staff available to complete reconciliations at the weekend, or outside normal pharmacy hours. This meant the service did not follow National Institute for Health and Care Excellence guidelines which state a medicines reconciliation should be completed within 24 hours.

There was no electronic prescribing system, however the trust planned to start this by the end of 2019.

**Incidents**

**Never Events**

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

From February 2018 to January 2019, the trust reported no incidents classified as never events for surgery.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from February 2018 to January 2019. All 12 serious incidents were reported at Warrington Hospital.

The types of incident reported were:
• Treatment delay meeting SI criteria with three (25.0% of total incidents).
• Surgical/invasive procedure incident meeting SI criteria with three (25.0% of total incidents).
• Pressure ulcer meeting SI criteria with two (16.7% of total incidents).
• Sub-optimal care of the deteriorating patient meeting SI criteria with one (8.3% of total incidents).
• Slips/trips/falls meeting SI criteria with one (8.3% of total incidents).
• Diagnostics incident meeting SI criteria with one (8.3% of total incidents).
• HCAI/Infection control incident meeting SI criteria with one (8.3% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Staff knew how to report incidents on the electronic incident reporting system. Change in practice following an incident would be discussed in the morning handover. Staff were aware of recent incidents and said lessons learned were shared through daily safety briefings.

We observed the matron explaining how to report incidents and how to escalate patient concerns to a new staff member. The staff rooms contained posters showing monthly trust wide lessons learned, called ‘sharing and learning together’.

Learning from incidents was shared on noticeboards which we observed, and at monthly team meetings. Staff also described receiving feedback following the trust safety briefing.

We observed a staff meeting in theatres and saw that staff were given information about incidents.

Staff were aware of the duty of candour. (Duty of candour is a regulation placed on health care providers to be open and transparent about when things go wrong in their care). We checked three serious incidents and found evidence that duty of candour was applied.

**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 seven new pressure ulcers, one fall with harm and 10 new urinary tract infections in patients with a catheter from January 2018 to January 2019 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Warrington and Halton Hospitals NHS Foundation Trust**

![Graph showing prevalence rates](image)
The service put actions in place to minimise the risk of pressure ulcers. Staff knew to change patients’ position every two hours, and use pressure relieving equipment; best practice was highlighted on the team brief.

The service participated in a falls collaborative to look at ways to reduce the risk of patients falling. This resulted in several methods being used including assistive technology such as falls sensors. Staff said they saw an improvement in the falls rate.
Is the service effective?

Evidence-based care and treatment

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

Staff worked to both trust policies and national guidance such as from the National Institute for Health and Care Excellence. Staff at different levels were encouraged to read guidance using the website, and staff could use an application on their smart telephones and electronic tablets. We saw evidence of staff following guidance.

Staff followed guidance to assess and reduce the risk of deep vein blood clot and pulmonary embolism (when a blood clot travels to the lungs). Staff followed guidance regarding how to diagnose, investigate, how to identify the severity and how to treat. We saw evidence in patient’s care plans of risk assessments and correct medicines.

Staff followed the pathway for the use of nasogastric tubes (tubes inserted into the nose and used to put liquid feed, water and medicines into the stomach). For example, the pathway instructs staff to avoid using the tube 48 hours post-surgery unless criteria are met.

Staff followed guidelines, available on the intranet, to treat patients with high potassium levels. Staff found these guidelines useful and accessible.

The service told us they were not compliant with the National Institute for Health and Care Excellence guidance for hip fracture analgesia in 2018, but that they had formed an action plan to improve performance and compliance and planned to re audit in 2019.

On the orthopaedic wards, staff followed the ‘fractured hip integrated care pathway’, and we saw completed pathways in patient records. This included a post-operative nursing assessment, whether the patient was alert, check for deep vein blood clot risk assessment, and whether the patient had medicines and compression stockings to reduce the blood clot risk.

Staff used the sepsis six pathway, advice provided by the UK Sepsis Trust to identify and start treatment quickly. All wards had information in staff offices and on notice boards.

We found that staff worked within the Association of Anaesthetists of Great Britain and Ireland guidelines for treatment of acute post-operative pain.

We found that each theatre was staffed in line with Association of Anaesthetists of Great Britain and Ireland guidelines. This included: two scrub practitioners, one health care assistant, one anaesthetic practitioner and one recovery practitioner.

The recovery area in theatres comprised eight bays and each was equipped as per Association of Anaesthetists of Great Britain and Ireland guidelines, including oxygen, suction and correct monitors.

The trust followed best practice for the use of medical devices and implants.

The service did not use electronic prescribing of medicines however there were plans in place to commence this.

Bariatric patients had access to a dietician and staff could hire equipment to meet the needs of patients.
Staff received training in how to deal with patients who were aggressive and staff described using distraction techniques and relaxation to help patients. However, staff told us this was not a common occurrence.

**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 planned for patients’ religious, cultural and other preferences.

Staff assessed nutritional needs using the malnutrition universal screening tool on admission, and we saw completed copies of these in 15 patient records checked. Staff weighed patients on admission and then weekly. All surgical wards had access to a dietician who monitored patients weekly.

The service provided high calorie supplementary menus for patients that required this and relatives could bring snacks to the ward. One patient told us they had received this as they were struggling to eat.

The service assessed for religious and cultural preferences and communicated this to the kitchen. Staff could request lighter meals and finger food meals for some patients, for example patients living with dementia, as staff found this worked better.

The ward used the red tray scheme for patients who required assistance to eat and drink and we saw evidence of this during the inspection.

Patients told us the food was good and that staff made hot drinks such as tea and coffee, malt drinks and hot chocolate. Patients waiting for low level procedures were offered refreshments as per trust policy.

Nutritional supplements were stored within a locked fridge in the treatment room, as the taste was more appealing when cold.

The trust managed post-operative nausea and vomiting in line with the National Institute for Health and Care Excellence guidance.

**Pain relief**

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

Staff assessed pain using the comfort bundles twice a day. Nursing staff asked patients about their pain as part of the nursing assessment and recorded a pain score in the notes which we saw. For patients who had difficulties communicating verbally, staff described noticing non-verbal body language such as wincing, facial expressions, deep breathing and whether a patient could cough.

We asked 20 patients whether their pain levels were being managed. 18 patients told us they had, and they described being regularly asked about their pain levels. Two patients said they felt their pain levels were not being managed, and one of the two patients experienced a delay due to faulty equipment.
The pain team had very close links with the surgical wards and was available between 7.30am and 6pm, Monday to Friday. We saw evidence in patient records where doctors had recommended a review by the pain team. The pain nurse produced plans to manage pain and staff told us that most patients had these. We spoke to two pain nurses who worked with patients to manage pain post operatively. Staff worked within the Association of Anaesthetists of Great Britain and Ireland guidelines for treatment of acute post-operative pain.

We found there was no section for pain on the national early warning score system. The service had recently trialled a pain booklet, which included a section for patients with cognitive impairment. Staff told us they were waiting for feedback about long term use.

The surgical leads told us that the trust was working on a new pain chart, including a section for cognitive impairment.

The service told us it was trialling a different method of pain relief with a new pump and found pain scores to be lower. Also, patients could be mobile and benefit from a lower risk of complications associated with post-operative immobility.

**Patient outcomes**

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

**Relative risk of readmission**

**Trust level**

From September 2017 to August 2018, all patients at the trust had a similar to expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a much higher than expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Graph showing relative risk of readmission for elective admissions](Image)

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

All patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
• General surgery patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
• Trauma and orthopaedics patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
• Upper gastrointestinal surgery patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Risk of Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>England Avg.</td>
</tr>
<tr>
<td>General surgery</td>
<td></td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td></td>
</tr>
<tr>
<td>Upper Gastrointestinal Surgery</td>
<td></td>
</tr>
</tbody>
</table>

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

**Warrington Hospital**

From September 2017 to August 2018, all patients at Warrington Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

• Ophthalmology patients at Warrington Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
• General surgery patients at Warrington Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
• Urology patients at Warrington Hospital had a much higher than expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions - Warrington Hospital**

The surgical leads told us they had developed new surgical guidelines including a new rota, which meant they could now review patients faster. The trust had taken a range of actions forward to improve the readmission rate including an extra ward round in the evening, admitting patients who did not need to stay overnight, the following day, and working closely with the discharge team. Managers told us they had seen an improvement in readmission rates.

All patients at Warrington Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
• General surgery patients at Warrington Hospital had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
• Trauma and orthopaedics patients at Warrington Hospital had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
• Upper gastrointestinal surgery patients at Warrington Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - **Warrington Hospital**

![Graph showing readmission rates for different specialties at Warrington Hospital compared to England average.]

*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 (September 2017 – August 2018))

**National Hip Fracture Database 2018**

The table below summarises Warrington 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>Meets national aspirational standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>73.3%</td>
<td>Bottom 25%</td>
<td>✗</td>
</tr>
<tr>
<td>Crude proportion of patients having surgery on the day or day after admission (It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)</td>
<td>63.8%</td>
<td>Bottom 25%</td>
<td>✗</td>
</tr>
<tr>
<td>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)</td>
<td>84.7%</td>
<td>Bottom 25%</td>
<td>✗</td>
</tr>
</tbody>
</table>
The trust had put a plan into place to make improvements. This included education about pressure ulcers on the ward, identifying high risk patients and increased monitoring. The trust increased staffing levels at the Cheshire and Merseyside Treatment Centre, to free up bed availability for fractured hip patients on ward A9 and improve outcomes.

### Bowel Cancer Audit 2017

The table below summarises Warrington and Halton Hospitals NHS Foundation Trust’s performance in the 2018 National Bowel Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national aspirational standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>45.4%</td>
<td>Poor (less than 50%)</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted post-operative length of stay &gt;5 days after major resection (A prolonged length of stay can pose risks to patients)</td>
<td>Not reported</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
<tr>
<td>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)</td>
<td>Not reported</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
varies according to whether surgery occurs as an emergency or as an elective procedure

<table>
<thead>
<tr>
<th>Risk-adjusted 2-year post-operative mortality rate</th>
<th>23.5%</th>
<th>Within expected range</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk-adjusted 30-day unplanned readmission rate</th>
<th>Not reported</th>
<th>N/A</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A potential risk for early/inappropriate discharge is the need for unplanned readmission)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection</th>
<th>52.1%</th>
<th>Within expected range</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>(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)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Bowel Cancer Audit)

National Vascular Registry 2017

The trust did not participate in the National Vascular Registry (NVR) audit.

(Source: National Vascular Registry)

National Oesophago-gastric Cancer Audit 2018

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

The table below summarises Warrington and Halton’s Hospitals NHS Foundation Trust’s 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>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level metrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Case ascertainment
(Proportion of eligible cases included in the audit)

| Proportion of eligible cases included in the audit | 0% to 40% | Worse | No current standard |

Age and sex adjusted proportion of patients diagnosed after an emergency admission
(Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)

| Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation | 12.9% | Better | No current standard |

Risk adjusted 90-day post-operative mortality rate
(Proportion of patients who die within 90 days of their operation)

| Risk adjusted 90-day post-operative mortality rate | Not eligible | N/A | No current standard |

Cancer Alliance level metrics
(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.)

| Cancer Alliance level metrics | 40.0% | Similar | No current standard |

(Crude proportion of patients treated with curative intent in the Cancer Alliance
(Proportion of patients receiving treatment intended to cure their cancer)

| Crude proportion of patients treated with curative intent in the Cancer Alliance | 40.0% | Similar | No current standard |

(Source: National Oesophago-Gastric Cancer Audit 2018)

National Emergency Laparotomy Audit 2017

The table below summarises Warrington Hospital’s performance in the 2017 National Emergency Laparotomy Audit. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment</td>
<td>100%</td>
<td>Green</td>
<td>✓</td>
</tr>
<tr>
<td>Crude proportion of cases with pre-operative documentation of risk of death</td>
<td>89%</td>
<td>Green</td>
<td>✓</td>
</tr>
</tbody>
</table>
Crude proportion of cases with access to theatres within clinically appropriate time frames
(Proportion of patients who were operated on within recommended times)

<table>
<thead>
<tr>
<th></th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
</table>
| Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre
(Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)

|                  | 92% | Green | ✓ |
| Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively
(Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)

|                  | 96% | Green/ | ✓ |
| 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)

|                  | 10% | Within expected range | No current standard |

(Source: National Emergency Laparotomy Audit 2017)

National Ophthalmology Database Audit 2018
(Audit of patients undergoing cataract surgery)


<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
</table>
| Trust-level metrics
(Measures of hospital performance in the treatment of cataracts
| Case ascertainment
(Proportion of eligible cases included in the audit)

|                  | 89.4% | Not applicable | No current standard |
| Risk-adjusted posterior capsule rupture rate
(Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm

|                  | 0.8% | Within expected range | No current standard |
from surgery and is widely accepted by surgeons as a marker of surgical skill.

<table>
<thead>
<tr>
<th>Risk adjusted visual acuity loss</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(The most important outcome following cataract surgery is the clarity of vision)</em></td>
</tr>
<tr>
<td>No data available</td>
</tr>
<tr>
<td>No data available</td>
</tr>
<tr>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Ophthalmology Database Audit 2018)

National Joint Registry 2018

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

The tables below summarise Warrington and Halton Hospitals NHS Foundation Trust’s performance in the 2018 National Joint Registry.

Warrington Hospital

<table>
<thead>
<tr>
<th>Trust-level</th>
<th>Metrics <em>(Audit measures)</em></th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level</td>
<td>Proportion of patients consented to have personal details included <em>(hips, knees, ankles and elbows)</em> <em>(Patient details help ‘track and trace’ 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)</em></td>
<td>82.2%</td>
<td>Similar</td>
<td>✗</td>
</tr>
<tr>
<td>Hospital level: Hips</td>
<td>Risk-adjusted 5-year revision ratio <em>(for hips excluding tumours and neck of femur fracture)</em> <em>(Proportion of patients who need their hip replacement ‘re-doing’)</em></td>
<td>1.0</td>
<td>Within expected range</td>
<td>✓</td>
</tr>
<tr>
<td>Hospital level: Hips</td>
<td>Risk adjusted 90-day post-operative mortality ratio <em>(for hips excluding tumours and neck of femur fracture)</em> <em>(Proportion of patients who die within 90 days of their operation)</em></td>
<td>1.0</td>
<td>Within expected range</td>
<td>✓</td>
</tr>
<tr>
<td>Hospital level: Knees</td>
<td>Risk-adjusted 5-year revision ratio (for knees excluding tumours) <em>(Proportion of patients who need their knee replacement ‘re-doing’)</em></td>
<td>0.5</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------</td>
<td>----------------------</td>
<td>----</td>
</tr>
<tr>
<td></td>
<td>Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) <em>(Proportion of patients who die within 90 days of their operation)</em></td>
<td>1.0</td>
<td>Within expected range</td>
<td>✓</td>
</tr>
</tbody>
</table>

(Source: National Joint Registry 2018)

National Prostate Cancer Audit

The table below summarises Warrington and Halton Hospitals NHS Foundation Trust’s performance in the 2017 National Prostate Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics <em>(Audit measures)</em></th>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>men with complete information to determine disease status <em>(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)</em></td>
<td>92.3%</td>
<td>N/A</td>
<td>✗</td>
</tr>
<tr>
<td>Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy <em>(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)</em></td>
<td>No data available</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy <em>(Complications following surgery may reflect the quality of surgical care)</em></td>
<td>No data available</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy</td>
<td>No data available</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>(External beam radiotherapy uses high-energy beams to destroy cancer cells)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Prostate Cancer Audit 2017)

Patient Reported Outcome Measures

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

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance on groin hernias was worse than the England average.

For varicose veins, performance was worse than the England average.

For Aberdeen varicose vein questionnaire was better for EQ-VAS and EQ-5D Index.

For hip replacements, performance was about the same as the England average.

For knee replacements, performance was about the same as the England average.

(Source: NHS Digital)
The ward managers participated in monthly audits and results were shared with staff and displayed on notice boards.

The trust was involved in monthly mortality audits and staff told us that lessons learned were discussed in team meetings. An example of learning from the audit included how to seek advice for acute kidney injury to prevent further deterioration.

Surgical leads planned to improve outcomes further by implementing the following for general surgery:

- enhanced recovery programme, including nurse-led care, enhanced recovery bay, pre-operative optimisation, use of written pathways.
- Look at wound infection rates and identify issues to be addressed.
- Employing a new consultant to increase the number of consultants who could remove gallbladders.
- Changes to the management and allocation of surgery lists to make sure the correct consultant was allocated.

Therapy staff on the surgical wards did not use national outcome measures. However, therapists worked with patients and relatives to find out patients’ baseline ability levels, what they wanted to achieve, and set goals from there. A common goal was to improve mobility. Therapists described working closely with family members to help patients achieve this.

Staff mentioned that therapists at the Halton site audited mobility on admission and thought this would be useful to use at Warrington.

**Competent staff**

The service made sure staff were competent for their roles.

**Appraisal rates**

**Trust level**

The trust had a target of 85% of staff having an appraisal by the end of the financial year. From April 2018 to December 2018, 70.4% of staff within surgery at the trust received an appraisal.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Eligible staff</th>
<th>Completed appraisals</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>140</td>
<td>108</td>
<td>77.1%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>183</td>
<td>136</td>
<td>74.3%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>17</td>
<td>12</td>
<td>70.6%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff – Hospital</td>
<td>83</td>
<td>54</td>
<td>65.1%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>40</td>
<td>24</td>
<td>60.0%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical (ST&amp;T) staff</td>
<td>37</td>
<td>22</td>
<td>59.5%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>10</td>
<td>3</td>
<td>30.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>510</strong></td>
<td><strong>359</strong></td>
<td><strong>70.4%</strong></td>
</tr>
</tbody>
</table>
Following the inspection, the trust provided us with the compliance at the end of the which showed that 84% of staff within surgery received an appraisal compared to a trust target of 85%. Qualified nursing staff did not meet the trust target with 78% appraisal rate. Medical staff had an appraisal rate of 100% which met the trust target. Other staff had a compliance of 83.7% which was just below the trust target.

**Warrington Hospital**

The trust had a target of 85% of staff having an appraisal by the end of the financial year. From April 2018 to December 2018, 68.9% of staff within surgery at Warrington Hospital received an appraisal.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Eligible staff</th>
<th>Completed appraisals</th>
<th>Appraisal rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>126</td>
<td>96</td>
<td>76.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>90</td>
<td>68</td>
<td>75.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>15</td>
<td>10</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental staff – Hospital</td>
<td>67</td>
<td>44</td>
<td>65.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>40</td>
<td>24</td>
<td>60.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical (ST&amp;T) staff</td>
<td>19</td>
<td>8</td>
<td>42.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>10</td>
<td>3</td>
<td>30.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>367</strong></td>
<td><strong>253</strong></td>
<td><strong>68.9%</strong></td>
<td><strong>85%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

The trust did not provide us with appraisal completion at the end of the year by hospital site.

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

During the inspection we spoke to a significant number of staff who reported working at the trust for many years, and thought the trust had a successful retention rate. Nursing and medical staff told us they received annual appraisals. Staff found these useful and led to further training and development.

The trust provided new staff with a comprehensive induction; nursing staff were supernumerary for the first four weeks and worked alongside a trained nurse. We spoke to one member of staff who had recently completed the induction which included: trust policies, falls policy, life support, sepsis and safeguarding training.

The trust implemented a clinical supervision programme following a successful pilot. New staff were automatically assigned to the programme and existing staff could sign themselves to receive support and mentoring. Staff we spoke to thought this worked well and felt supported and able to discuss concerns. Ward managers had an open-door policy to provide informal supervision.

The trust supported senior nurses to undertake training to be a clinical supervisor, and staff completed this through the University of Chester. The service was encouraging all staff to sign up to the clinical supervision programme. Service leads told us if performance issues were identified, managers would sign staff onto the programme.

Therapy staff we spoke to on the surgical wards were part of a ‘rotation’. The level of clinical supervision depended on the type of rotation. Therapists employed via an agency received supervision through their agency.
The service welcomed students and wards A6 and A5 were trialling collaborative learning in practice. This meant students were responsible for their own patients, attended meetings and contributed to care planning. Staff felt this worked well and helped students take ownership of their work. One student we spoke to described really enjoying the course and felt part of a team. Another student felt it was better than working with only one mentor and told us they would like to work for the department when they qualified.

The trust had service specific competencies for staff to achieve and records were held electronically. In theatres, the service made sure that a nurse trained in advanced life support was on every shift and this was highlighted on the theatre information board. This was an improvement following the last inspection.

The resuscitation team completed acute illness management every three years. At ward level band two and above staff were trained in basic life support; band five and above nurses were trained in intermediate life support. Staff could access the medical emergency team and resuscitation team who were trained in advanced life support.

Managers identified risks to performance through the performance management system. Poor performance was addressed with support from the human resources department and putting an action plan in place. Staff could have extra supervision and training, or move to a different ward which their skills would suit better.

**Multidisciplinary working**

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

All relevant staff were involved in assessing and delivering care. All surgical wards employed occupational therapists and physiotherapists, and all wards accessed the dietician and speech and language therapy. Therapy staff undertook assessments of patients and set therapy goals with patient and family involvement. The arrangements for multidisciplinary meetings differed on each ward; they occurred between every three days or daily. The nursing handover occurred first, between 7.30 and 8am, followed by the multidisciplinary team meeting at 9am which the nurse attended.

We observed a multidisciplinary meeting and found there was good interaction between all professionals. Members included the consultant, ward manager, occupational therapy, physiotherapy, and discharge co-ordinator. The meeting focussed on the diagnosis, treatment and discharge plan, and any complications. Therapists could clarify concerns with the consultant and ask questions openly, for example confirming whether patients could weight bear to complete physiotherapy exercises.

We spoke to therapy staff who told us that multidisciplinary meetings were very useful and clarified tasks and goals. We found all types of staff worked well together and were not protective over individual roles. During the inspection we observed good interaction between different levels of staff, for example between physiotherapy and nursing staff following an assessment of a patient.

Staff worked well with other departments within the trust. Therapy staff could refer patients to the intermediate care team and worked alongside them to co-ordinate discharge and treatment plans. Staff used the electronic referral system to refer patients to other teams including the pain team, safeguarding team and palliative care team. Staff found the system easy to use.
Staff including the surgical assessment team worked alongside community teams to assist palliative care patients to return home in a timely way. The surgical assessment unit had a seven-day open door policy which meant patients who were concerned could return to the unit, for example to have dressings changed.

Discharge planning started as soon as patients were admitted, and there was a section in patient records to document this. Discharge summaries were automatically sent electronically to GPs. Patients took discharge checklists home which contained the ward number and telephone numbers about who to ring with concerns.

**Seven-day services**

The trust provided surgery seven days per week.

Therapy shifts were from 8.30am to 4.30pm, five days per week. Staff thought that at times patient goals were set back due to not receiving therapy at the weekend.

Medical shifts were between 9am and 5pm, 5 days per week; on-call was used for out of hours.

There were two theatre sessions per day, between 9am and 6pm, Monday to Friday. During the weekend there were two trauma sessions per day between 9am and 5pm, or until procedures finished. The emergency theatre was open 24 hours per day, seven days per week.

Pharmacy cover was not available outside normal working hours.

**Health promotion**

The service promoted patients’ health in different ways.

The surgical wards had patients who wished to reduce their alcohol intake. Staff could refer patients to the alcohol liaison nurse who worked with patients to achieve this.

The service also had smoking cessation strategies and could prescribe nicotine patches to patients who wanted this.

The patient boards in the wards had information regarding nutrition and hydration with advice on how to increase fluid intake to stay healthy. We saw details of an ‘afternoon tea’ event which was promoted to provide dietary advice.

The trust had joint ‘schools’ which patients could attend to learn about how to take care and what to expect following surgery.

Ward A9 looked at ways to improve health and wellbeing for patients living with dementia. This included stimulation therapy and a reading programme.

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

Staff had some understanding about how and when to assess whether a patient had the capacity to make decisions about their care.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that from April 2018 to December 2018, Mental Capacity Act (MCA) training was completed by 96.6% of staff in surgery compared to the trust target of 85%. Qualified nursing
and health visiting staff had a completion rate of 92.7% and medical staff had a completion rate of 95.0%.

A breakdown of training completion by all staff by site is shown below:

- Warrington Hospital: 96.0%

Over the same period Deprivation of Liberty Safeguards training was completed by 67.5% of staff in within surgery compared to the trust target of 85%. Qualified nursing and health visiting staff had a completion rate of 51.0% and medical staff had a completion rate of 61.0%.

A breakdown of training completion by all staff by site is shown below:

- Warrington Hospital: 68.2%

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

Staff discussed patients’ mental capacity issues during every safety huddle to be aware of patients with cognitive impairment. Staff could describe the principles of the Mental Capacity Act, for example, using least restrictive methods of care and treatment. Staff were aware of the need to involve patients’ relatives or an independent mental capacity advocate. Different levels of staff completed mental capacity assessments, such as nurses, social workers and therapists, in line with guidance.

We saw completed mental capacity assessments in most patient records we checked and requests for Deprivation of Liberty Safeguards. Staff knew to contact the safeguarding team for any patients at risk of a deprivation of liberty. The safeguarding team kept a list of patients who had authorisations in place and when renewals were due. One ward kept their own paper file of patients who had a Deprivation of Liberty Safeguards authorisation.

However, we found that in two cases mental capacity assessments and best interests decisions were not recorded in patient records, although it was stated in notes that the patient ‘lacked capacity’ and treatment was taken in their best interests.

We found that one patient had been admitted to the ward due to intoxication and was treated in their best interest. The patient had been diagnosed as autistic and a member of staff felt the patient therefore lacked capacity and submitted a deprivation of liberty application. No capacity assessment was undertaken and the patient had capacity to consent to treatment.

There was good interaction between staff on the ward and mental health services, ensuring staff could keep the patient safe.

We checked 15 patient records and found that consent was always recorded. Staff obtained consent during the pre-operative appointment, which could be a few days or weeks before the surgical procedure, to allow the patient time to consider. The consultant and anaesthetist re-visited patients in the surgical assessment unit to go through the procedure and consent form again on the day, which we saw evidence of in patient records. One patient told us that staff checked and re-checked their name and date of birth, and they signed a consent form twice.

We observed four patients going into theatre for surgery and saw that all four patients’ consent was obtained prior to the procedure.
We saw one do not attempt cardiopulmonary resuscitation form in a patient record which was completed correctly. Staff told us that resuscitation specialists provided training for doctors to complete the forms.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Friends and Family test performance

The Friends and Family Test response rate for surgery at Warrington and Halton Hospitals NHS Foundation Trust was 35%, which was better than the England average of 27% from January 2018 to December 2018.

Warrington Hospital (WH) had a response rate of 29%.

A breakdown by ward across all sites, including Cheshire and Merseyside Treatment Centre (CMTC) - located on Halton site - is shown below. There was a data issue in January 2018.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resop</th>
<th>Percent recommended</th>
<th>Annual perf</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAU - SURGICAL ASSESSMENT UNIT - W</td>
<td>593 45%</td>
<td>NA N/A 97% 94% 94% 94% 98% 98% 98% 98% 98% 98% 98% 98%</td>
<td>98%</td>
</tr>
<tr>
<td>BAH - DAYCASE - WARD B4 - H</td>
<td>699 50%</td>
<td>N/A N/A 97% 94% 94% 94% 94% 94% 94% 94% 94% 94% 94%</td>
<td>94%</td>
</tr>
<tr>
<td>OCOU - DAYCASE - HALTON DAY CASE UNIT - H</td>
<td>503 26%</td>
<td>N/A N/A 95% 92% 92% 92% 92% 92% 92% 92% 92% 92% 92%</td>
<td>92%</td>
</tr>
<tr>
<td>CBH - DAYCASE - INPATIENT WARD - CMTC</td>
<td>632 51%</td>
<td>N/A N/A 94% 92% 92% 92% 92% 92% 92% 92% 92% 92% 92%</td>
<td>92%</td>
</tr>
<tr>
<td>DOS - DAYCASE - OPHTHALMIC DAY SURGERY - W</td>
<td>579 33%</td>
<td>N/A N/A 92% 92% 92% 92% 92% 92% 92% 92% 92% 92% 92%</td>
<td>92%</td>
</tr>
<tr>
<td>DGSH - DAYCASE - ORAL SURGERY DEPARTMENT</td>
<td>441 21%</td>
<td>N/A N/A 90% 90% 90% 90% 90% 90% 90% 90% 90% 90% 90%</td>
<td>90%</td>
</tr>
<tr>
<td>CMDDC - DAYCASE - DAY CASE TREATMENT CENTRE - CMTC</td>
<td>396 50%</td>
<td>N/A N/A 97% 95% 95% 95% 95% 95% 95% 95% 95% 95% 95%</td>
<td>95%</td>
</tr>
<tr>
<td>NG - WARD A - W</td>
<td>200 17%</td>
<td>N/A N/A 90% 90% 90% 90% 90% 90% 90% 90% 90% 90% 90%</td>
<td>90%</td>
</tr>
<tr>
<td>DOS - DAYCASE - ORAL SURGERY DEPARTMENT</td>
<td>200 17%</td>
<td>N/A N/A 90% 90% 90% 90% 90% 90% 90% 90% 90% 90% 90%</td>
<td>90%</td>
</tr>
<tr>
<td>CMDDC - DAYCASE - DENTAL DAY CASE WARD - W</td>
<td>250 75%</td>
<td>N/A N/A 95% 95% 95% 95% 95% 95% 95% 95% 95% 95% 95%</td>
<td>95%</td>
</tr>
<tr>
<td>CMDDC - DAYCASE - DENTAL DAY CASE WARD - W</td>
<td>191 43%</td>
<td>N/A N/A 90% 90% 90% 90% 90% 90% 90% 90% 90% 90% 90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

The highest score to lowest score

| Key | 100% | 50% | 0% |

4. The total responses exclude all responses in months where there were less than five responses at a 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.

The day case treatment centre at CMTC had the highest response rate with 85%, whilst ward A6 at Warrington Hospital had the lowest response rate with 17%.

(Source: NHS England Friends and Family Test)

We saw several examples of staff taking the time to interact with patients and talking in a warm and friendly way. For example, in the day case area, staff spent time with a patient before and after an eye procedure, which the patient felt anxious about. As relatives were worried about parking, nursing staff assisted the patient to meet their relatives at the main reception.

All wards and the surgical assessment unit maintained the dignity and privacy of patients. All bays were single sex with clear signs to inform. Staff in the surgical assessment unit assisted patients to change into gowns and made sure that patients were covered with a blanket during transfer from the unit to theatre. We observed a patient going to theatre with a blanket over their legs and staff talked to the patient in a manner to put them at ease. The service introduced privacy capes for patients receiving breast surgery.
Ward A4 organised a wedding within a few hours for a palliative care patient. The team arranged a registrar, decorated the room, arranged cake and flowers and helped the bride to get ready. The staff then turned the room into a honeymoon suite for the night.

We spent time in the ward and found that staff attended to patients straight away when buzzers were pressed.

Staff described staying in the department late to make sure all jobs were completed and to take the time to speak to patients and their families.

We spoke to 11 patients and they reported that the level of care was excellent, they felt comfortable and received pain relief on time. Most patients told us they did not have to wait or be moved during the night. Patients told us their buzzers were answered quickly. Patients said they would use the hospital again and would recommend to their friends and family. One patient out of 11 told us they had to wait for pain relief and was moved between wards at 3.30am.

Another patient felt they did not receive the right amount of help to mobilise to the toilet, as they had been assessed as ‘independent’.

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

We found many examples of staff providing emotional support to patients and their families. Staff understood the impact care had on people, particularly for palliative care patients. For example, staff spent time talking to patients and relatives and planned for relatives to be comfortable using recliner chairs and staying in rooms overnight.

All the patients we talked to spoke highly of staff and said they were supported. The wards displayed ‘thank you’ cards which highlighted that patients felt supported during their admission. A patient told us that staff always smiled and were very good at making conversation to put them at ease pre- and post-operatively.

We saw many interactions between staff and patients and found that staff provided patients with information to cope with their condition and treatment. This included information on discharge summaries about who and how to contact if they had any concerns.

One patient described the staff as ‘calm, caring and comfortable’.

The service had access to psychology support and made referrals to the mental health liaison team. Staff said the team was responsive and could see patients within the same day of referral.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment.

Patients told us that staff always introduced themselves and spent time explaining conditions and treatment. At the entrance to each ward was information about staff on shift, with photographs of lead nurses and ward managers.

A patient told us that communication from the surgical department was excellent. For example, in the day case unit staff always sent a follow up appointment in writing. The letter explained what to expect during the appointment so that patients could come prepared.
Staff knew to arrange for interpreters for people with additional communication needs. Staff understood the importance of this when discussing a procedure and gaining consent.

We found that therapy staff worked well with patients and their relatives to set therapy goals and treatment plans. Therapists involved families to plan successful patient discharge.
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The service had specialist leads for different areas. For example, a dementia champion and pain leads. The service could access learning disability leads.

All wards had a large electronic visual display which highlighted any patients who had additional needs, for example a mental health condition or learning disability. There were no symbols above patient beds to identify a condition, however patients wore a yellow band if they had cognitive impairment or high falls risk.

The trust recently established a trust wide alert system to make the senior nursing team aware when a patient with a learning disability was admitted. This prompted a welfare check and support for the ward, patient and their families with individualised care planning and assessments. In October 2018, 12 patients were identified and two people had supported admissions.

The trust delivered training for learning disabilities every fortnight to support improvements in the compliance rates. This was supported by a number of easy read documents for staff. This remains an area of focus for ward managers due to the low rates reported in the quality metrics figures.

The service completed 'you said, we did' posters on notice boards to reflect how the service improved, for example providing free television between 8am and 12 noon. Noticeboards contained information about the patient liaison service if patients wanted to raise a concern.

Previously short falls were identified in the surgical assessment unit. In response the service visited other trusts including Salford and Milton Keynes before developing the service at Warrington. Staff felt proud of what they now delivered.

Patients were sent a text message to remind them of their appointment, and were informed of cancellations ahead of time. Patients knew how to cancel their appointment and this was always followed up in writing.

Patients and staff both commented that parking availability was very poor.

Meeting people’s individual needs

The service took account of patients’ individual needs.

People’s individual needs were highlighted during handovers. Some needs were highlighted on the electronic system.

Staff in the surgical assessment unit received theatre lists the day before which meant they could plan. For example, a patient that had a learning disability or autism could be assigned the first or last slot of the day. Staff moved items out of the treatment room to provide the patient with privacy, and make the area seem less ‘clinical’. Staff made sure that discharge was planned as soon as possible.

We found that staff made care person centred. The service could be flexible, for example staff would remove trolleys in treatment areas to accommodate patients who used a wheelchair, and provide a chair for carers.
The service provided single side rooms for patients who were distressed or confused. Staff made sure patients had someone they knew with them when they came around from general anaesthetic, or staff provided extra support.

Patients were assessed on admission regarding level of care required. Staff provided patients with ‘enhanced care’ meaning patients received one-to-one care from staff. Wards had a dementia box which contained games, pictures, visual aids and other items to help relax patients.

Families were asked to complete a ‘this is me’ document for patients with cognitive impairment and we saw these completed in patient records. This meant staff could understand patients and their needs and wishes quickly. Patients could have a care passport to inform staff of their health and condition.

Staff could use the individual plan of care to support palliative patients. This included pain, wishes and preferences, relatives’ wishes, and religion. Staff felt this provided a framework for patients, their relatives and staff. Doctors completed ceiling of care for palliative patients which meant all staff were aware of patients’ wishes and any limitations to treatment.

The department had a translation service and staff made use of interpreters when needed.

When we asked about menus in different languages, staff provided this straight away.

Staff described adjusting for religion and cultural reasons. For example, making use of cubicles so patients could pray with their families, and staff made sure there was a sign on the door, so the family were not interrupted.

Wards did not have any bariatric equipment, however, staff had quick access to rented equipment including beds, chairs and commodes.

Staff made referrals to the mental health team.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

The surgical assessment unit admitted patients referred by their GP, from accident and emergency alongside elective patients. Staff managed this by keeping lists separate, and there was a dedicated trauma theatre to reduce cancellations of elective procedures. There were five trolleys and 13 chairs to accommodate patients in the surgical assessment unit.

To avoid admissions and reduce length of stay, the service looked at whether patients could remain as a day case and be discharged within eight hours; this improved bed availability. For low level procedures patients from accident and emergency could go home and return to the Halton site the following day.

Regular patients who required a drain could ring the ward directly to arrange and avoid presenting at accident and emergency.

There was an early discharge lounge which staff said helped to achieve timely discharges for patients.

The unit looked at different ways to aid access and flow. For example, the ward manager on the surgical assessment unit completed the nurse prescribing course to improve discharge times. This was arranged following feedback from patients who said they had to wait too long for medicines.
prescriptions. The assistant practitioner took elective patients to theatre to aid flow within the service.

Patients commented that they were not kept waiting long. Patients were advised of what number they were on the theatre list. Anaesthetists worked closely with the surgical assessment unit to inform of any delays. This helped manage patient’s and relative’s expectations and people could have a drink and go for a walk.

Staff told us they could access test results electronically, for example blood test results. We found that the day case unit could complete blood tests for patients and waited approximately one hour for the results.

Staff could access a machine to check patient’s hearts (electrocardiogram). Doctors told us chest x-rays and ultrasounds were completed quickly. We found there were waiting lists to use magnetic resonance imaging scanners (machines which take pictures of parts of the body) and usually had to wait one or two days.

Out of hours, the accident and emergency department arranged scans for patients, which we were told could happen quickly. There was a radiology hub that provided magnetic resonance imaging scans and other types of scans out of hours for several trusts.

Staff said that handovers assisted access and flow. All relevant staff were together, so issues could be addressed and clarified straight away. Wards had systems in place to inform staff when tasks such as a scan were completed; staff could then arrange safe discharge. Staff told us the system worked and discharges were smooth and efficient.

**Average length of stay**

**Trust Level – elective patients**

From October 2017 to September 2018, the average length of stay for all elective patients at the trust was 3.2 days, which is lower compared to the England average of 3.9 days.

- For trauma and orthopaedics elective patients at the trust was 3.5 days, which is similar compared to the England average of 3.8 days.
- For general surgery elective patients at the trust was 4.2 days, which is similar compared to the England average of 3.9 days.
- For urology elective patients at the trust was 2.4 days, which is similar compared to the England average of 2.5 days.

**Elective Average Length of Stay – Trust Level**

![Graph showing average length of stay for different specialties at the trust compared to England average.](image)

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

**Trust Level – non-elective patients**
The average length of stay for all non-elective patients at the trust was 4.8 days, which is the same as the England average of 4.8 days.

- The average length of stay for general surgery non-elective patients at the trust was 3.5 days, which is similar compared to the England average of 3.7 days.
- The average length of stay for trauma and orthopaedics non-elective patients at the trust was 9.5 days, which is higher compared to the England average of 8.6 days.
- The average length of stay for upper gastrointestinal surgery non-elective patients at the trust was 4.3 days, which is similar compared to the England average of 3.9 days.

**Non-Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4.8</td>
<td>4.8</td>
</tr>
<tr>
<td>General surgery</td>
<td>3.5</td>
<td>3.7</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>9.5</td>
<td>9.6</td>
</tr>
<tr>
<td>Upper Gastrointestinal Surgery</td>
<td>4.3</td>
<td>3.9</td>
</tr>
</tbody>
</table>

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

**Warrington Hospital - elective patients**

From October 2017 to September 2018, the average length of stay for all elective patients at Warrington Hospital was 4.3 days, which is similar compared to the England average of 3.9 days.

- The average length of stay for general surgery elective patients at Warrington Hospital was 5.6 days, which is higher compared to the England average of 3.9 days.
- The average length of stay for urology elective patients at Warrington Hospital was 3.0 days, which is higher compared to the England average of 2.5 days.
- The average length of stay for trauma and orthopaedics elective patients at Warrington Hospital was 6.7 days, which is higher compared to the England average of 3.8 days.

We asked surgical leads what actions were in place to improve outcomes. We found they had made improvements in the way this type of surgery was scheduled, completed length of stay reports and meetings, and linked in with community teams to plan for discharge. Managers told us they had seen improvements in the post-operative length of stay.

**Elective Average Length of Stay - Warrington Hospital**

Note: Top three specialties for specific site based on count of activity.
Warrington Hospital - non-elective patients

The average length of stay for all non-elective patients at Warrington Hospital was 4.7 days, which is similar compared to the England average of 4.8 days.

- The average length of stay for general surgery non-elective patients at Warrington Hospital was 3.5 days, which is similar compared to the England average of 3.7 days.
- The average length of stay for trauma and orthopaedics non-elective patients at Warrington Hospital was 9.4 days, which is higher compared to the England average of 8.6 days.
- The average length of stay for upper gastrointestinal surgery non-elective patients at Warrington Hospital was 4.3 days, which is similar compared to the England average of 3.9 days.

Non-Elective Average Length of Stay - Warrington Hospital

<table>
<thead>
<tr>
<th>Specialty Grouping</th>
<th>This Site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4.7</td>
<td>4.8</td>
</tr>
<tr>
<td>General surgery</td>
<td>3.5</td>
<td>3.7</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>9.4</td>
<td>8.6</td>
</tr>
<tr>
<td>Upper Gastrointestinal</td>
<td>4.3</td>
<td>3.9</td>
</tr>
</tbody>
</table>

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

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

From December 2017 to November 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was better than the England average, except for December 2017 and August 2018 where performance was similar. In the latest period, November 2018, performance was 77.3%, compared to the England average of 65.8%.

(Source: NHS England)

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

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

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>86.4%</td>
<td>72.2%</td>
</tr>
<tr>
<td>Specialty grouping</td>
<td>Result</td>
<td>England average</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>84.8%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>65.2%</td>
<td>59.3%</td>
</tr>
</tbody>
</table>

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

(Source: NHS England)

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’s performance was below the England average for five out of eight quarters. From April 2017 there was a rise in the percentage of cancellations with a peak of 27% of 41 cancelled surgeries not treated within 28 days from April to June 2018. In the latest two quarters there has been improvement and in the latest quarter, October to December 2018, this trust cancelled 63 surgeries. Of the 63 cancellations 3% weren't treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Warrington and Halton Hospitals NHS Foundation Trust

Over the two years, the percentage of cancelled operations at the trust followed the trends of the England average but with better performance. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

Cancelled Operations as a percentage of elective admissions - Warrington and Halton Hospitals NHS Foundation Trust
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Summary of complaints

From December 2017 to December 2018, there were 77 complaints about surgery. The trust took an average of 25 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 60 working days for high graded complaints and 30 working days for moderate and low graded complaints.

- Warrington Hospital: There were 60 complaints. Of these, 43 (71.7%) were about patient care (Source: Routine Provider Information Request (RPIR) – Complaints tab)

We checked one complaint during the inspection and found that duty of candour had been applied. Patients we asked told us they knew how to raise concerns.

Number of compliments made to the trust

From January 2018 to December 2018, there were six compliments about surgery.

- Warrington Hospital: Five compliments (83.3%) (Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Managers were skilled and knowledgeable about their service. Leaders were visible and approachable to staff. Junior doctors told us that senior leaders were visible, for example participating in junior doctor forums, and they felt senior leaders listened to and acted on their concerns. Nursing staff saw their matrons daily and could request to see them if they required support.

The trust made leadership programmes available, for example the ward managers development programme which supported staff to develop their skills. Staff were supported to complete the clinical supervision leadership programme.

All levels of staff we spoke with said they felt supported and encouraged to complete continuing professional development. Staff were allowed sufficient time to develop skills through mentors. All new nursing staff were put on the trust 12-month preceptorship program. Support included monthly teaching sessions, clinical supervision, simulation sessions, core competencies, and resilience training. There was a separate ‘dummy’ theatre for staff to develop competencies such as invasive procedures.

There was a designated consultant nurse that supported the development of advanced practice. The surgical team promoted research-based practice to improve clinical practice.

The trust encouraged staff to become specialists in their roles and many staff thought this was beneficial and helped to achieve the trust vision. Leaders worked closely with specialist teams, to consult on treatment management plans.

Leaders understood the challenges they faced, for example financial constraints. Leaders were looking at ways to alleviate such as improving links with community teams to reduce the pressure on inpatient services. An example of this included developing a community audiology service, providing trust level expertise in the community. Another example was developing pathways for patients with mental health conditions to access services.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The vision of the surgical department was to provide clinical effectiveness and outstanding care. Leaders told us that working in partnership with staff helped to maintain and improve standards and quality, and kept patients safe. Sustainability and transformation were of focus and the service was involved in the regional transformation projects and system partners ‘One Halton’ and ‘Warrington Together’. Work was underway on working with other healthcare providers to share expertise and develop partnership working and collaboration on various surgical projects.

Leaders felt that well-functioning teams were integral to the performance of both the surgical department and wider trust.
Staff we spoke to felt engaged with the trust vision and strategy. They described providing safe and excellent standards of care, and working in partnership.

A new member of staff told us the trust induction included looking at the trust vision and all staff wore cards highlighting values including ‘working together, excellence, accountable, role models, embracing change’. Staff we spoke to felt values were genuine.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

We spoke to a range of staff at different levels including housekeepers, health care assistants, nurses, therapists, ward managers, junior doctors, theatre specialists and consultants. Many staff we spoke to had worked for the trust for many years, or returned after working for a different trust. One member of staff had worked for the trust for 33 years and described 'loving the job'. Staff commented that the trust were good at retaining staff and they were happy in their work.

Managers and leaders promoted a positive culture in various ways. For example, students in the surgical assessment unit put together noticeboards to visibly reflect what made them proud. Answers included quality and team working.

Staff described feeling proud of providing the best possible care to patients. Staff were encouraged to identify where practice could be improved and providing a solution. Staff felt the trust provided a comfortable culture, with various channels to get help and support.

Staff we spoke to were aware of the duty to be open and honest about patient care and could describe the duty of candour. Duty of candour is a regulation put on providers to be open, honest and transparent when things go wrong in their care. Several staff described the culture as being open and honest and knew who their freedom to speak up guardian was.

The trust recognised when staff had done well through the ward accreditation scheme and celebrated success. Wards were recently awarded the silver award accreditation and staff were proud of this. Wards received stickers when they received an accreditation. Members of staff could win awards for good practice.

**Governance**

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There were three clinical business units within the surgery department: specialist surgery, musculoskeletal, and digestive diseases. All units had a clinical director, clinical business manager and lead nurse. The musculoskeletal unit included an allied health professional lead also. This gave a clear structure to provide effective processes and systems of accountability; all senior leaders had clear roles and remit.

There was evidence of good clinical governance procedures and quality measurement processes. These ensured risks were identified and escalated through a series different committees and steering groups to trust and executive level. Messages and issues could be escalated up through
the committees to senior manager and executive levels and equally messages could be delivered top down to staff on the ground.

The units functioned effectively and members of staff worked well together. Clinical excellence and best practice was shared across the three units. Staff described sharing of detailed investigations helped to improve best practice. We saw that the units did not operate in isolation and there was good cross unit communication and collaboration.

There were ward meetings every Friday and staff received a ward update via electronic mail.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service had a comprehensive risk register. Risks were rated and reviewed monthly; all risks had a risk owner attached. The risk registers detailed controls and assurances, and actions needing to be taken. Risks with a higher risk score were escalated to the corporate risk register and reviewed through the board and the sub-committees of the board.

The service established a theatre transformation board to improve productivity and efficiency. Initiatives to improve performance included changes to the safer surgery practices, pre-admission courtesy calls and utilisation initiatives. The team had made some positive improvements and were in the process of implementing further changes which would improve practices in the operating theatres.

Surgical leads acknowledged the risk caused by the suspension of spinal surgery, and the impact financially and to patients. Surgical leads worked with an acute trust locally to provide a spinal service at the Cheshire and Merseyside Treatment Centre (a different site but part of the Warrington and Halton Trust) in the future. Managers told us the other trust would provide the governance for the new model, described as ‘hub and spoke’.

Managers echoed concerns about staffing levels, which was found at the last CQC inspection also. A staffing plan had been put in place to improve, including a rolling recruitment programme.

The service took part in a range of audits including weight bearing in ankle fractures and compliance with surgical site marking forms both of which led to improvements in practice. Results of audits were presented at monthly governance meetings and changes to practice were highlighted to staff through safety bulletins, electronic mail and meetings.

The ward accreditation system measured the quality and performance of wards. Wards recently received the silver award accreditation showing good performance.

Managers identified risks to performance through the performance management system. Poor performance was addressed with support from the human resources department and putting an action plan in place. Staff could have extra supervision and training, or move to a different ward which their skills would suit better.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
The trust had a data standards and assurance group that met monthly and reported into the information governance and corporate records sub-committee. This reported to the quality assurance committee of the board. The board reviewed requests for new data capture and changes to data capture. The group reviewed the NHS Digital data quality dashboard which showed that the trust's performance was above the national average for most key fields, and monitored areas for improvement.

The digital board held suppliers to account to make sure system errors causing data errors were acted upon and resolved. Daily quality reports monitored completeness of data and corrected any errors. Checks included accuracy and timeliness of automatic reports sent outside of the organisation (for example, discharge summaries).

The trust's key performance indicator group reviewed activity and performance to investigate data and abnormal patterns giving a better understanding of the data and activity levels.

The trust used an external benchmarking tool which reviewed progress in relation to other trusts, looking at mortality, referral patterns and activity.

The service used an electronic recording system which staff said helped them in their role. The system meant discharge summaries could be sent automatically and securely to GPs. The service knew to report information to external bodies, such as the Care Quality Commission, clinical commissioning groups and local authorities.

Financial performance was reported for each clinical business unit using a monthly dashboard with a wide range of financial metrics.

All wards had a large electronic visual display which showed which bays patients were in. the screen contained icons to highlight issues such as falls risk, dementia and infection.

**Engagement**

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

The trust arranged various ways to engage staff. These included the ‘listening to action scheme’ and staff survey. Ward A9 were involved in a ‘what can be improved’ initiative.

There was a monthly health care assistant forum and staff contributed to developing the service through this.

The trust had programmes to recruit staff from different countries and support was given with finding housing, human resources support, references and language.

Staff could access a buddy network for peer support.

The trust provided a chaplain and mixed faith rooms for both patients and staff.

The trust engaged with patients in different ways. The service sought patient feedback and a patient experience was fed back at monthly team meetings.

Noticeboards in all area highlighted patient experience results. There was also a topic board which changed monthly and during the inspection the topic was nutrition and hydration.

**Learning, continuous improvement and innovation**
The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The trust participated in a range of internal and external reviews. These included the mortality review and staff told us that lessons were learned and practice changed as a result.

Managers had effective performance management oversight of staff and put things in place to support staff who were identified as having development needs, such as increased mentoring, training or providing clinical supervision.

We found that staff worked together to review and redesign processes, for example the development of the surgical assessment unit. Staff visited other sites to share best practice and make improvements to patient care and treatment.

The trust linked in with three virtual fracture clinics. This meant staff could review x-rays without the need for patients to come to hospital. Staff informed patients of results and advised if a follow up appointment was needed.

Service leads told us they looked at different ways to improve services by investing in staff and career progression. For example, through training, and support to become a lead nurse.

All junior doctors were given a project for quality improvement. An example of this included a benchmark project for the treatment of fractured hip and comparison to other trusts. Another example included making prescriptions for stockings to treat deep vein blood clots clearer. Staff told us that practice had changed and improvements were being made as a result.

In May 2018 the team organised a trip to climb Mount Snowdon to raise money for an electrocardiogram (test which measures the electrical activity of the heart).
Critical care

Facts and data about this service

The trust has 21 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Warrington and Halton Hospitals NHS Foundation Trust and England.

This trust

- Neonatal, 14.3%
- Adult, 85.7%

England

- Neonatal, 24.2%
- Pediatric, 5.8%
- Adult, 70.1%

(Source: NHS England)

The adult critical care unit is an 18-bedded ward situated on the Warrington site. Care is delivered across two areas allowing level three and level two patients to be grouped if required. The unit participates in Intensive care national audit and research centre (ICNARC) and in the Infection in critical care quality improvement programme (CCQIP) national surveillance programme looking at bloodstream infections in critical care units.

The unit ward delivery model includes: Consultant ward rounds 8am-8pm Monday to Friday and 8am-5pm weekends offering twice daily ward rounds. Dedicated 1 whole time equivalent Band 8a Pharmacy cover Monday to Friday with plans for seven days.

There is an electronic rostering system for junior, middle and consultant staff. There is formalised handover sessions and daily multidisciplinary team huddles along with ward multidisciplinary team meetings and mortality and morbidity meetings, which include radiology.

The trust has trainee advanced critical care practitioners (ACCPs) with dedicated consultant clinical supervision.

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

Mandatory training was carried out mainly on e-learning with some classroom training based, for example; moving and handling.

In critical care the 85% target was met for eight of the 10 mandatory training modules for which qualified nursing staff were eligible. Resuscitation level one training module had the lowest completion rate of 33.3%, however, this was based on three eligible staff. Performance should be taken in context when dealing with small numbers of eligible staff.

The trust set a target of 85% for completion of mandatory training.

Mandatory training completion rates

Warrington Hospital

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 at Warrington Hospital for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</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>Infection prevention and control - level 1 - 3 years</td>
<td></td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Counter fraud - No renewal</td>
<td></td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td></td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td></td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td></td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td></td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 1 - 3 years</td>
<td></td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td></td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS Conflict resolution (England) - 3 years</td>
<td></td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td></td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not provide medical staff mandatory training data.

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

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

Staff we spoke to had a good understanding of safeguarding and knew how to contact the safeguarding team and make a referral. The safeguarding referral form was easily assessible on the intranet and staff knew where to find it. One nurse we spoke with gave us examples of numerous referrals to the safeguarding team. The team would respond to a request to attend the unit straight away.

Staff were aware of female genital mutilation and it was included in the mandatory training. In addition, flyers had been disseminated to the staff in critical care to embed awareness.

A band five nurse in critical care had brought back knowledge to the teams having had a special interest role within the safeguarding team. Other staff could approach her for advice.

If patients on the unit were at risk of suicide, or self-harm it was flagged on their patent records for referral to a psychiatrist, however, the psychiatrist did not visit the patient whilst undergoing care in the unit. Due to the 1:1 care on the unit and the environment such patients were deemed to be safe. This was followed up on discharge to another ward, or home.

We saw arrangements to keep patients at risk of suicide or self-harm safe. Policies and procedures were in place for extra observation, supervision or restraint, if needed for patients.

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.

Warrington Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 at Warrington Hospital for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>3</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>3</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>2</td>
</tr>
</tbody>
</table>

In critical care the 85% target was met for two of the three safeguarding training modules for which qualified nursing staff were eligible.

The trust did not provide medical staff safeguarding training data.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

We visited a range of areas including clinical areas, offices, corridors, store rooms, sluices, relative’s rooms and staff areas, all of which appeared to have been cleaned to a high standard.

Feedback from patients and relatives collected between October 2018 and February 2019 also made comment to the cleanliness of the unit, with one relative saying ‘the place was immaculate’

We saw cleaning records for the three areas of critical care, however, the paper records stopped at the beginning of February 2019 as the domestics were told that they no longer needed to keep records as the house keeper would inspect the areas for cleanliness and would record it electronically.

During the inspection we observed staff appropriately washing their hands, using antiseptic hand gels and wearing personal protective equipment (PPE) when delivering personal and clinical care.

We also spoke to relatives, who had all observed this practice.

The most recent validated ICNARC data for 1 April to 30 September 2018 showed that the unit had; no case of unit-acquired methicillin-resistant Staphylococcus aureus (MRSA), one patient with unit-acquired Clostridium difficile infection (C- Diff), one case of unit-acquired VRE and one unit-acquired infection in blood. This showed that the unit performed better than similar units.

On entering an insecure domestics cleaning cupboard on the unit we found bottles of cleaning products stored on the shelves. Patients and visiting persons could assess the room, we addressed this with the leads at the time of our visit and it was resolved during the inspection

The unit had a green sticker system for signalling that equipment had been cleaned, we found green stickers on equipment which we found to be clean in corridors and store rooms.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The design, layout and maintenance of the unit was well used and kept people safe. The combined high dependency unit (HDU) and intensive care unit (ICU) was spacious, well equipped and light, due to natural light from external windows.

The unit could accommodate 11 level three patients and nine level two patients.

The unit was secured with a buzzer entrance door.

The unit also had a counselling/quiet room, which was used for staff to have private discussions with patients and was also used overnight if relatives wanted to stay on the unit.

The equipment for each bed space was centralised around a ceiling pendant which meant that all the equipment could be moved to wherever the patient was positioned.

The service had a system for categorising equipment for maintenance. Each piece of equipment within critical care had an asset number and was categorised; high, medium high, medium low or low risk. The computer system enabled engineers to schedule maintenance around the risk categories, so that no piece of equipment went overdue.

The frequency of equipment replacement was dependant on the manufacturers’ recommendations. In order for the engineers not to miss a deadline they would sometimes reduce
the manufacturers’ recommended date, for example the infusions needed maintenance carried out every three years, however, the engineers did this every two year.

For repairs, 90% of the equipment in critical care was repaired in house by the medical engineers, taking into consideration whether it was cost effective and whether their engineers had the correct skills to repair the equipment.

If equipment failed on the unit it was the staff member’s responsibility to report the problem and take it out of service and either take it directly to the medical engineers, or store safely for them to collect. Staff were then responsible for completing a requisition form, detailing the problem and identifying themselves and the date they removed the equipment. This prevented any equipment going back into service before being fixed.

We were told that the medical engineers attended critical care several times a week, checking on the safety and maintenance of the equipment. The medical engineers were available 365 days a year 24 hours a day, providing advice to staff and would attend if equipment needed fixing urgently, for example a monitor.

The rolling replacement programme meant that all monitors and ventilators in critical care had been replaced in the previous 12 months prior to our visit and all ITU Ventilators. The replacement programme ensured that the medical engineers could see electronically the full history of equipment.

The manufacturers of some equipment provided technical training to the medical engineers, in order for them to have the skills to maintain the equipment. The manufacturers would also train the staff on the unit in how to operate the equipment.

The medical engineer manager attended a medical devices safety group every two months, chaired by the director of governance and attended by the medical director and representatives from all clinical areas. They also attended a monthly capital purchasing group.

The medical engineers ensured that all equipment in critical care conformed to the relevant safety standards and that there was a controlled system overseen by the British standards institute. British standards institute audit (BSI) conducted an annual audit and the results for the last audit for June 2018 showed there were no issues.

The unit had two isolation rooms with negative and positive ventilation. Single-bed rooms with lobbies are required for the isolation of patients to control the spread of infection or for the protection of immunosuppressed patients. Department of Health Building Note 04-02 sets out the standards and says that no unit should have less than 20% of their beds as isolation beds.

In addition to a difficult airway trolley the unit had a stabilisation trolley and when it was first put together in 2016, was believed to be the only trolley like it in any intensive care unit in the UK. The trolley was aimed to meet the needs of the patients by having the right equipment in the right place at the right time. When deteriorating patients are admitted to ICU the first few hours involve a process of stabilisation. This stabilisation process is very complex. It involves: anaesthetising the patient with anaesthetic medicines, intubating with airway equipment, attaching a ventilator and maintaining ventilation with sedation medicines, providing IV fluids and inotrope medicines. This process is time critical and good outcomes very much depend on speed of action.

The staff at Warrington ICU had commented on a lack of efficiency in stabilising deteriorating patients admitted to ICU, the trolley was put together to improve this. The trolley consisted off; a custom-made anaesthetic box, medicines and labels, airway equipment and intubation equipment, rapid sequence induction checklist (for intubation), sedation medicines and inotrope medicines.
and infusion equipment, IV fluids and infusion equipment, nasal gastric (NG) feeding tube, aseptic pack (dressing pack, hat, mask etc). The aim of the trolley was to improve the time critical period to stabilise a deteriorating patient, improve teamwork and leadership within ICU, to improve outcomes, early stabilisation and mortality methods.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

The critical care unit managed patient risk well and staff identified and responded appropriately to changing risks to patients.

Patients on admission received an assessment for venous thromboembolism (VTE) and bleeding risk using the clinical risk assessment criteria described in the national tool. We looked at eight patient records and saw that the VTE risk assessment had been recorded as conducted on five of the patients.

The national early warning score system, NEWS (2) was introduced on the unit in September 2017 and staff had e-learning and the unit held a promotion for awareness prior to roll out. An audit was carried out in the January 2018 for compliance, which was based on their own policy.

All patients we reviewed records for had been screened on admission for MRSA and every Tuesday during their stay in critical care.

An acute care team was available 24 hours a day seven days a week. This consisted of an outreach team who were available across the hospital from 8am to 8pm and at night the acute care team responded to risk across the hospital, which included; medical emergencies, cardiac arrests, deteriorating patients and any patients that triggered five or above on the national early warning scores, as well as reviewing patients who had been discharged from critical care.

The outreach team also visited all emergency laparostomy patients, acute fractured neck of femur, acute kidney injury and any level three alerts from the laboratories to check guidelines were being followed.

The acute care team also attended the medical handovers and trust safety briefings to feedback any issues from the night.

The acute care team consisted of 11 whole time equivalent (WTE) band seven acute care nurses specialists and trainee advanced nurse practitioners (ANP). There was also two WTE assistant practitioners to conduct clinical skills.

The outreach critical care consultants conducted four ward rounds a week (Monday, Tuesday, Wednesday and Friday) reviewing all patients around the hospital who were under the outreach team.

Within the unit nine band seven nurse were trained in advanced life support. All members of the acute care team were advanced life support trained. All band five and six nurse were intensive care support (ICS) trained.

The service told us it was currently looking at competencies for staff in advanced airways skills and band six and seven nurses had been trained since the last inspection so that there was an appropriately trained member of staff available on every shift. At the time of our inspection 23
members of staff were trained in the department and two newly appointed band seven nurses were scheduled to attend the training in spring 2019.

Staff had assistance if a patient required advanced airway techniques and would follow an intubation check list and bleep an operating department practitioner.

Nurse staffing

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

The service met the national standards for staffing. When necessary the unit used bank and agency staff to fill gaps in the rotas. The bank staff used were staff who worked regularly on the unit. The unit did not use more than 20% of registered nurse from bank/agency staff on any one shift when they were not their own staff.

The unit had the right number of nurses and the right skill mix for the acuity of patients. The unit had HDU and ICU patients mixed together. All staff looked after all levels of patients.

A number of nurses in the acute care team had qualified as advanced nurse practitioners and a further three nurses were being trained. Advanced nurse practitioners are highly experienced and educated nurses who are able to assess, investigate and diagnose, and prescribe.

There were standardised handover procedures. Once a ward bed was allocated to the patient, nursing staff on the unit informed the speciality team and gave a medical handover. An audit conducted in December 2018 showed 80% compliance.

All patients that have been ventilated for more than three days were invited back to Critical Care follow up clinic. At this clinic, a member of the improving access to psychological therapies (IAPT) was present, and could signpost patients to psychology services as required.

Agency staff received a local induction to the unit which consisted of a form to complete on line, however, a new local induction had started the week before our visit. This had been shaped by the learning from a recent serious incident. To check the competency of agency staff for local surgical interventional procedures, a number of forms had been produced for the member of staff to read and sign to say they were aware of the process. These included; tracheostomy, chest drain, nasogastric tube, central line, bronchoscopy and rapid sequence induction. These new competency, safety check lists had gone into circulation at the end of March 2019.

There was a standardised handover procedure for medical and nursing staff, both for shift handovers and discharge of patients back to parent teams.

Planned vs actual

The trust has reported their nursing staffing numbers below from April 2017 to March 2018 and from April to November 2018 in critical care. The fill rate decreased between the periods as although there was little difference in the actual staff WTE the planned WTE had increased from 75.6 to 80.9.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>75.6</td>
<td>66.8</td>
</tr>
</tbody>
</table>
Vacancy rates

We looked at vacancy rates for the service for April 2019 and saw that the service was appropriately staffed and even on occasions overstaffed. The average occupancy for April 2019 for day staff was 88% and night staff 86%.

<table>
<thead>
<tr>
<th></th>
<th>Day %</th>
<th>Night %</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2018</td>
<td>88</td>
<td>86</td>
</tr>
<tr>
<td>May 2018</td>
<td>90</td>
<td>87</td>
</tr>
<tr>
<td>June 2018</td>
<td>87</td>
<td>85</td>
</tr>
<tr>
<td>July 2018</td>
<td>86</td>
<td>84</td>
</tr>
<tr>
<td>August 2018</td>
<td>85</td>
<td>84</td>
</tr>
<tr>
<td>September 2018</td>
<td>87</td>
<td>84</td>
</tr>
<tr>
<td>October 2018</td>
<td>91</td>
<td>89</td>
</tr>
<tr>
<td>November 2018</td>
<td>91</td>
<td>89</td>
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<tr>
<td>December 2018</td>
<td>90</td>
<td>89</td>
</tr>
<tr>
<td>January 2019</td>
<td>90</td>
<td>91</td>
</tr>
<tr>
<td>February 2019</td>
<td>100</td>
<td>94</td>
</tr>
<tr>
<td>March 2019</td>
<td>96</td>
<td>93</td>
</tr>
</tbody>
</table>

Turnover rates

From December 2017 to November 2018, Warrington Hospital reported a turnover rate of 28.3% for qualified nursing staff in critical care. This was higher than the trust target of 13%.

Sickness rates

From December 2017 to November 2018, Warrington Hospital reported a sickness rate of 6.6% for qualified nursing staff in critical care. This was higher than the trust target of 4.3%.

Bank and agency staff usage

Warrington Hospital

From December 2017 to November 2018, the trust reported 16,768 (11.3%) bank hours and 5,013 (3.4%) agency hours at Warrington Hospital were filled by qualified nursing staff in critical care. There were 4,710 hours (3.2%) that were not filled by bank/agency staff.

A ward breakdown is shown below:
### Site/ward

<table>
<thead>
<tr>
<th>Site/ward</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive care unit (ICU)</td>
<td>148,196</td>
<td>16,768 11.3%</td>
<td>5,013 3.4%</td>
<td>4,710 3.2%</td>
</tr>
</tbody>
</table>

During the same period, the trust reported 587 (2.0%) bank hours and 22 (0.1%) agency hours were filled by nursing assistants in critical care at Warrington Hospital. There were 125 hours (0.4%) that were not filled by bank/agency staff.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Site/ward</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive care unit (ICU)</td>
<td>29,427</td>
<td>587 2.0%</td>
<td>22 0.1%</td>
<td>125 0.4%</td>
</tr>
</tbody>
</table>

The trust reports that it “continues to strive to reduce bank and agency reliance for all services. Non-qualified nurse agency spend is almost non-existent and bank usage is tackled through our recruitment drives to fill our vacancies.”

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

### Medical staffing

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

The unit had nine consultants, which included two dedicated to critical care. Two consultants covered Monday to Friday 8am to 5pm and one consultant 5pm to 8pm. 8pm to 8am the consultants were available to the unit on-call.

Consultants responsible for patients on the unit were free from other clinical commitments.

The consultants worked on a rolling rota and covered each other’s shifts if they were unavailable, All consultants on-call were available to attend the unit within 30 minutes 24 hours a day, seven days a week.

Consultants carried out twice daily ward rounds in the critical care unit, reviewing each patient. This was an improvement from the last inspection and was now in line with Guidelines for the Provision of Intensive Care Services (2015) standards. The improvement had come by splitting the ward round into two with a consultant leading each ward round, this was more efficient and prevented multidisciplinary teams being away from their respective roles, for a considerable time. The two team would meet up after to share notes.

Patients in critical care were reviewed by a consultant within 12 hours of admission. We looked at eight patient records and seven showed evidence of review.

We spoke to a speciality anaesthetic and critical care doctor who carried an on-call bleep for the ward. Any referrals from accident and emergency or the wards, would be attended by the speciality doctors to review and access the patient and a discussion with the consultant would determine whether the patient would be admitted to critical care.
The medical handovers were attended by both consultants from the unit, the outreach consultant, the two night-doctors, doctors from the day shift, the nurse in charge, advanced nurse practitioners and medical students.

The consultants were all up to date with their re-validation.

**Planned vs actual**

The trust has reported their medical staffing numbers below from April 2017 to March 2018 and from April to November 2018 in critical care. The service fill rate has decreased from 87.5% to 76.6% but the service has a planned staff increase of 10 WTE and has nearly doubled their actual staff WTE.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>8.0</td>
<td>7.0</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

We looked at staffing levels from April 2018 to March 2019 and the service was continually appropriately staffed and even over staffed on occasions.

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

**Turnover rates**

From December 2017 to November 2018, Warrington Hospital reported a turnover rate of 0.0% for medical staff in critical care. This was lower than the trust target of 13%.

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

**Sickness rates**

From December 2017 to November 2018, Warrington Hospital reported a sickness rate of 0.8% for medical staff in critical care. This was lower than the trust target of 4.3%.

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

**Bank and locum staff usage**

**Warrington Hospital**

From December 2017 to November 2018, the trust reported 1,267 (6.3%) bank hours and no locum hours at Warrington Hospital were filled by medical staff in critical care. There were no hours that were not filled by bank/locum staff.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Site/ward</th>
<th>Total hours available</th>
<th>Bank Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
</tr>
<tr>
<td>Intensive care unit (ICU)</td>
<td>20,081</td>
<td>1,267</td>
</tr>
</tbody>
</table>
The trust reported an additional 19,029 central bank hours worked which were not able to associate with a specific speciality.  

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

Records

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

Critical care used paper records for patients, although across the trust electronic patient notes were used. Leads for critical care told us that they anticipated to be electronic by May/June 2019.

We looked at eight sets of records and saw that they were well written and managed in a way that kept people safe, this was an improvement on the last inspection. However, although the time a consultant reviewed the patient on admission to critical care was recorded, time of decision to admit the patient to the unit was only recorded four times out of eight records we looked at.

There were no paper care plans for patients, however we saw good evaluation of care for each patient we reviewed and electronic care plans were present. We were told by critical care leads that they were planning to trial the use of a paper, booklet care plans which was used throughout the trust in other areas.

Systems were in place to identify patients with pre-existing mental health conditions. During our visit we looked at three patients records in relation to patients who had made suicide attempts. We saw that that capacity and mental health were managed well.

The mental health team would not visit patients in ICU to carry out assessments. This was due to patients being physically unwell and not having capacity until they had recovered sufficiently. When patients were moved to other wards, the mental health team would get involved and work with them as appropriate. Mental health rehabilitation was considered following discharge from ICU.

All patient records in critical care were kept in a key-code secure locker by the nurse’s station. Each isolation room had a secure locker for the individual patients notes.

The dieticians reviewed the patient electronic notes but recorded their notes on paper in the nursing notes.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medicine at the right dose at the right time.

Medicines were prescribed and administered appropriately for the patients we reviewed. The allergy status was recorded for all patients.

Antimicrobial treatments were prescribed, however not all prescriptions had review or stop dates documented; the indication for the antibiotic was not always recorded. A medicines reconciliation had been completed for most of the records reviewed. NICE guidelines recommend a medicines reconciliation is completed within 24 hours. The pharmacy department report the medicines reconciliation rate as 26-28%, which is well below the expected rate of 90%. There were no
pharmacy staff available to complete reconciliations at the weekend, or outside normal pharmacy hours.

The service had a five-day pharmacy service from a senior critical care pharmacist during core hours. The pharmacist support on the ward was not to the level recommended by the Faculty for Intensive Care Medicine. Staff discussed concerns around governance, training of staff and maintaining guidance due to the reduced support. From 1 April 2019 a 1 whole time equivalent senior critical care pharmacist was starting in post. The newly appointed pharmacist would be supported by the principal pharmacist for critical care, providing extra support into the daily ward rounds to meet the Guidelines for the Provision of Intensive Care Services (2015) standard. The service told us it would be extended to seven days per week, once the pharmacy consultation had concluded by the end of May 2019, initially with a pilot in place.

Pharmacy staff provided a twice weekly medicine top up service to the wards; expiry dates were checked by the staff. There was no evidence of any out of date medicines.

Medicines were stored securely, and regular checks were performed to ensure controlled drug stock levels were correct.

Fridge checks were not always completed daily, in line with the medicines management policy. This had been an issue raised at the previous inspection. Audits carried out in 2018 for the drug fridge temperature recording compliance, showed poor compliance. It was noted at the inspection ward treatment rooms were not temperature checked. Medicine fridges were monitored and found to be within range.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The unit had one never event in the last 12 months which was also a serious incident. 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 most recent never event was concerning a nasogastric tube being inserted into the patient’s lungs and resulted in the death of the patient. The incident was investigated by the trust and reported appropriately and escalated to the nursing and midwifery council. The incident was discussed at a weekly harm meeting, chaired by the director of governance. Although the investigation was still on going, learning had already been taken from the incident and the local induction for agency staff had been developed, incorporating additional local surgical interventional safety check lists.

We saw evidence that lessons were learned and themes identified and actions taken as a result of investigations when things went wrong. Nursing staff were updated on incidents via the daily safety briefs on the unit and were also emailed about the incident.

The unit held a mortality and morbidity monthly meeting, reviewing all deaths for the unit, which was attended by critical care consultants, junior doctors, critical care leads, the practice educators and the consultant lead for ICNARC. These meetings were attended by multidisciplinary teams (MDT) and was fed up to the trust mortality review group and fed into service improvement. This had been an improvement since the last inspection.
We looked at 17 ICU mortality reviews, for seven we saw evidence of discussion and learning. It was not clear whether there had been no learning from the remainder reviews, or that it had not been recorded.

We were told by managers that there was an open reporting culture among staff. Staff were aware of how to raise an incident and knew how to report an incident on the incident reporting system.

The unit had systems in place for reviewing and investigating safety and safeguarding incidents and events when things went wrong. The critical care lead had undergone a two-day investigation training course for senior management.

Management told us when staff error has been highlighted from an investigation, national competencies and the framework for critical care were revisited with that member of staff.

We looked at the most recent never event and duty of candour had been applied in a timely manner. 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. The consultant had informed the family immediately after the incident and the critical care lead took on the role as family liaison, writing to the family to confirm duty of candour and continued to update them on the progress of the investigation by telephone and email.

The unit monitored safety thermometers; pressure ulcers, falls, catheter associated UTI, Venous thromboembolism.

There was an open reporting culture across the unit and all staff we spoke to new how to report an incident on the intranet and were happy to escalate any concerns to the management team.

**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 February 2018 to January 2019, the trust reported one incident classified as a never event within critical care which was a misplaced nasogastric tube.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from February 2018 to January 2019.

The types of incidents reported were:

- One pressure ulcer meeting SI criteria
- One diagnostic incident including delay meeting SI criteria (including failure to act on test results)
- One slips/trips/falls meeting SI criteria
- One surgical/invasive procedure incident meeting SI criteria (the above never event)
Safety thermometer

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

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 two new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from January 2018 to January 2019.

(Source: NHS Digital – Safety thermometer)

The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and ‘harm free’ care. Safety thermometer data was submitted from the unit and reported at trust level. This included data on patient falls, pressure ulcers, urinary catheter related infections and episodes of venous thromboembolism.

Safety thermometer data was collected and displayed in public areas for patients and relatives to view. A new board was erected during our visit at the entrance to the unit, which displayed all information clearly.

There had been no pressure ulcers in critical care since May 2018.
Is the service effective?

Evidence-based care and treatment

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

The lead for critical care developed ‘always events’ which concentrated on effective treatment and processes for patients and highlighted it to staff. Recently a project had highlighted the benefits of head bed elevation, by tilting the angle of the hospital bed at a 45-degree angle. Adults in critical care on ventilators have an increased risk of contracting ventilator associated pneumonia (VAP). It is a leading cause of death in critically ill patients. The angle at which ventilated patients lie may play an important role in preventing the infection of their lungs. The critical care lead presented this ‘always event’ at a conference to staff and disseminated posters to make them aware.

Staff were able to deal with violence and aggression in an appropriate way using manual restraint. They were trained in a skilled hands-on method of physical restraint to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose was to safely immobilise the service user. This was in accordance with NICE NG10 guidelines in short term management in mental health. However, only band seven nurses had received the restraint training.

The discharge documentation we reviewed was good and included medical and nursing summaries. The Situation, Background, Assessment, Recommendation (SBAR) was followed. A technique to ensure communication is effective on handover and information is transferred accurately about the patient.

On reviewing the patient records, we saw evidence of regular use of Richmond agitation scores (RASS, this is the first steps in administering the CAM-ICU) and Confusion Assessment Method (CAM-ICU). This score is a validated and commonly used score to help monitor patients for the development or resolution of delirium.

We saw evidence of well documented patient discharge from nurses and the medical teams. National Early Warning Scores (NEWS) were also conducted prior to discharge to other wards.

All nursing staff on the unit were trained in delirium and we saw evidence in patient records that patients were tested for delirium within 12 hours of admittance to the unit and this was regularly audited.

Nutrition and hydration

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

Dieticians saw all new admissions, referrals and any patients that needed clinical input to the unit and reviewed their electronic care plan. All eight patient records we reviewed showed that they had all been seen by a dietician. The records also evidenced that all eight patients had their fluid state/balance reviewed.

We saw evidence on all records we reviewed that malnutrition universal screening tool (MUST) scores were being calculated for patients and that referral to dietic services were being made when needed. The dieticians reviewed the ‘MUST’ scores on the patient records. ‘MUST’ is a five-
step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. This was an improvement since the last inspection as this was not consistently done for each patient.

Critical care staff participated in more than 21 local audits, which included; compliance of MUST scores, ICU Consultant reviews and the quality of post-operative IV fluid documentation. We looked at these audits, amongst others, the last MUST score audit in May 2018 showed 100% compliance by ICU staff on completion of MUST scores on patient’s admission. The last audit for ICU Consultant reviews showed 100% compliance, however the audit for quality of post-operative IV fluid documentation in June 2018 was poor, which prompted the service to develop an action plan for improvement.

The dietician for critical care had a split post, but would attend Monday to Friday on the unit, either in the morning or afternoon. We were told that there was a business case for more funding for an addition dietician to work in critical care. A suggested ratio would be 0.05-0.1 whole time equivalent (WTE) dietitian per ICU bed as per Core Standards for Intensive Care. There was no dietician available out of hours, weekends, or bank holidays.

On discharge home the dietician would give advice to the patient and family. If they missed the patient discharge they would follow-up with a phone call to the patient and offer an outpatient appointment if necessary. If the patient was transferred to another trust, the dietician would contact the dietician at that trust to discuss the patient’s nutritional and hydration needs and fax a summary of care.

**Pain relief**

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

We reviewed eight patients’ records and saw pain scores were recorded appropriately and pain was discussed at ward rounds for all eight patients.

The unit had access to a pain team available to support patients on the critical care unit. The pain team did not routinely visit the unit but would attend on referrals made to them.

There were processes in place to access patient’s pain and the pain scores were recorded on the patient’s care records and monitored.

**Patient outcomes**

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

The unit participated in National audits in collaboration with the Cheshire and Mersey adult critical care network. Every care bundle had its own audit, ongoing audits at the time of our visit were for; ventilator, nutrition, SSKIN (a five-step approach to preventing and treating pressure ulcers) and renal patients. Each audit lasted four weeks and ten level three patients were randomly selected for the audit each month.

The unit also audited care bundles at local level, which included ventilator-associated pneumonia and Local safety standards for invasive procedures (LocSSIPS). These were led by the team leaders and every patient in critical care were audited.
The unit demonstrated submission of continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This meant that the care delivered and mortality outcomes were being monitored against the performance of similar units nationally.

We reviewed the latest validated and published ICNARC data for the period July to September 2018 which showed no alerts for the unit. Discharge home was the only area where the trust was shown as ‘amber’. Discharges direct to home for the unit was 14% compared to similar units being 11%. We spoke to the critical care lead who told us this area was subjective, ICNARC scored a high percentage as an area for improvement as it was believed that patients who were discharged directly home from critical care may miss out on a follow-up appointment, or links to additional support. An example of a patient who had been admitted and discharged direct from the unit would be a person who had taken an overdose. There was a thorough and effective follow-up process for discharged patients at the unit and a new policy had been produced for all discharges from the unit.

Results of the ICNARC data were emailed out to all staff for them to keep updated on where the unit scores Nationally.

We spoke to junior doctors who were encouraged by the consultants to conduct audits, two ongoing audits were looking at; live insertion and acute kidney injury.

**ICNARC Participation**

The trust has one unit which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. Any available quarterly data should be considered alongside this annual data.

The table below summarises Warrington Hospital’s performance in the 2016/17 ICNARC Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude non-clinical transfers</td>
<td>0.0%</td>
<td>Within expected range</td>
<td>✓</td>
</tr>
<tr>
<td>(Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude, non-delayed, out-of-hours discharge to the ward proportion</td>
<td>0.2%</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>(Discharge out-of-hours is associated with increased risk of mortality)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours)</td>
<td>8.0%</td>
<td>Not in the worst 5% of units</td>
<td>✗</td>
</tr>
</tbody>
</table>
| (Discharge from critical care should be within four hours of decision to
discharge and occur as early as possible in the day

<table>
<thead>
<tr>
<th>Risk-adjusted hospital mortality ratio (all patients) (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</th>
<th>1.0</th>
<th>Within expected range</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% (‘lower risk’ patients) (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td>1.3</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

Competent staff

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

Newly qualified nurses received a 10 to 12-week induction, supernumerary on the unit and other new staff received a ten-week supernumerary period. We spoke to a newly qualified nurse on the unit who told us she was given a 10-week supernumerary period.

The critical care leads held teaching every Friday for all staff on the unit and covered a variety of clinical topics and procedures. An empty bed space would be used on the ward and a member of staff, or an actor would be used for simulation.

At the time of the inspection 42% of nursing staff had completed a post registration critical care qualification. By September 2019 this would rise to 48% with four more staff completing the qualification. A further 8 nurses (11%) would start the training in September 2019. This was below the 50% in the National Standards for Adult Critical Care Nurse Education. The trust had a standard that staff would need to work within the critical care department for a minimum of two years before starting a qualification. Of the remaining staff, 21 (29%) had not yet worked for two years so were not yet eligible to start the training and 8 (11%) were close to retirement, on maternity or long term sick leave.

Appraisal rates

The trust had a target of 85% for the completion of appraisals by the end of the financial year. From April 2018 to December 2018, 80.0% of staff within critical care at the trust received an appraisal compared to a trust target of 85%.
### Core service

<table>
<thead>
<tr>
<th>Core service</th>
<th>Eligible staff</th>
<th>Completed appraisals</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>49</td>
<td>43</td>
<td>87.8%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>22</td>
<td>18</td>
<td>81.8%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>12</td>
<td>6</td>
<td>50.0%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85</strong></td>
<td><strong>68</strong></td>
<td><strong>80.0%</strong></td>
</tr>
</tbody>
</table>

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

At the time of our inspection, in March 2019, 98% of staff had received an annual appraisal. One hundred per cent of medical staff had received an appraisal, 96.9% of nursing staff and 100% of other staff.

### Multidisciplinary working

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

We observed good multidisciplinary team working in all areas. We observed ward rounds, huddles, handovers and specialist ward rounds such as with the microbiologist, all teams interacted well, shared information and supported each other.

A post ward round huddle took place which we observed. It was a structured meeting between; two consultants, the nurse in charge, four specialist registrars, physiotherapist and pharmacist. Each patient was discussed and their ceiling of treatment.

Communication with band seven nurse was good and the consultants spoke to the nurses each morning for an update on the bed state and to ascertain the elective admissions planned for that day.

### Seven-day services

We found support care delivered seven days a week by multidisciplinary teams to the patients in critical care.

The ward rounds were consultant led and occurred everyday including weekends and national holidays. We observed a ward round during our inspection which consisted of five staff; consultant, nurse in charge, two specialist registrars and a physiotherapist.

A microbiologist ward round would take place every day at 2pm to review that the patient was on the most appropriate antibiotic.

A dedicated 1.00 whole time equivalent band 8a pharmacist covered the unit Monday to Friday with plans to extend this to seven days.

Patients who were transferred from critical care to a general ward were reviewed by the outreach team.
Health promotion
Health promotion leaflets were readily available in the waiting room and included; ‘Eating well to get better’ and ‘sleep benefits’.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. We saw one patient who was combative and challenging and trying to pull out their nasal gastric tube. Protective mittens were applied to prevent removal of the tube and other equipment/leads. Use of mittens was discussed with the patient and a risk assessment completed. A capacity assessment was carried out due to the patient’s confused state and combative manner. The patient was found to lack capacity to consent to treatment. A Deprivation of Liberty (DoLS) application was submitted on the same day however, the patient deteriorated significantly and therefore the DoLS was no longer required. Nursing staff checked with safeguarding leads to ensure they had taken the appropriate action.

Mental Capacity Act and Deprivation of Liberty training completion
The trust reported that from April 2018 to December 2018, Mental Capacity Act (MCA) training was completed by 98.7% of support to doctors and nursing staff in critical care compared to the trust target of 85%. During the same period, 91.0% of support to doctors and nursing staff completed the Deprivation of Liberty Safeguards (DoLS) training.

Both the MCA and the DoLS training modules were stated to be ‘no renewal’ by the trust and no other staff group in critical care were said to be eligible in the time frame of data given.

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

Compassionate care

Staff always cared for patients with compassion. Patients and family members said staff consistently treated them well and with kindness.

We looked at patient and relative feedback collected between October 2018 and February 2019, there were 29 responses, all of which gave positive feedback. The comments referred to the kindness of staff in the unit; ‘Kind and engaging’, ‘Staff very caring towards patients and relatives’, ‘They took into consideration personal needs.’ One family had said they were constantly informed and updated on their relative's condition and staff were calm, supportive but still kept them ‘sane’ with their sense of humour.

The kindness and compassion from staff was evident everywhere. Staff had raised money to purchase Christmas presents for a teenager whose single parent had been admitted to the unit, over the festive period. On Christmas day the staff provided the teenager with a Christmas dinner and presented him with a number of Christmas gifts.

Feedback from patients and relatives also showed that the staff interacted with people who used the service and those close to them in a respectful and considerate way. One family commented that staff spoke to their loved one at all times, even when they were sedated. Another relative said that their loved one had limited communication, but staff spoke to the patient and gave them reassurance.

Patient diaries were in use in the unit, but the understanding of their use was variable. Intensive care patient diaries are a simple but valuable tool in helping patients come to terms with their critical illness experience. After critical care patients have been discharged they often report having gaps in their memory from their illness. Diaries enable patients to make sense of their intensive care experiences and they reduce the risk of developing depression, anxiety and post-traumatic stress disorder (PTSD) for both patients and relatives. We found that some patient diaries had been started, but had stopped once the patient was awake.

Staff on the unit respected personal, cultural, social and religious needs of people. A multi faith memorial service was held annually by the unit, arranged by staff on the unit and all relatives and friends were invited by letter to attend. The annual service had been held on the Sunday prior to our visit and we saw photographs from the service. The unit had sent out tags with the invitations and relatives wrote a message dedicated to the person they had lost and some attached photographs. On the day of the service a local supermarket donated flowers for each attendee and the tags were attached to the flowers and laid out during the service. Staff also arranged for a local school choir to sing at the service and during the service the names of all the loved ones was projected on the wall. The service was held in the post graduate lecture theatre with 130 attendees. Staff who were off duty attended the service and baked, supplying refreshments for after the service.

In addition to the memorial service, the unit held a condolence book and a letter was sent out after the death of patients asking if they would like their loved one’s name in the book.

We saw staff making sure that peoples’ privacy and dignity needs were understood and respected. During physical and intimate care examinations curtains were pulled round the bed spaces.
The unit the space within the unit well and had an additional room to take relatives to talk to in private. We saw staff sensitively taking a family to the private room who were distressed. This avoided the patient and other patients getting upset and disturbing visitors in the waiting room.

**Emotional support**

People’s emotional seen as being as important as their physical needs. Staff provided emotional support to patients to minimise their distress.

We saw staff speaking to patients and family sensitively and offering emotional support.

The former patients’ physical and psychological needs were discussed at the follow-up clinics and their progress since discharge. A representative from Warrington psychological service also attended the clinic, who could refer the patient to a psychologist if necessary. The outreach clinics were well attended with approximately four former patients attending each month.

Patient diaries were bound and presented to the patient at the clinic, and discussions held over their content.

A local ICU steps support group was held every two months, outside the hospital setting. This was a drop-in session for discharged patients to meet in an informal setting and share their experiences of being a critical care patient with other people who had similar experiences.

Patients on the unit were seen by a dietician daily.

The unit had a counselling room in addition the family waiting room where nurses and Doctors supported families in private.

Patients had their physical and psychological needs regularly assessed and addressed. Staff handovers routinely referred to the psychological and emotional needs of patients. Patients with mental health issues and patients who were admitted after attempt suicide were referred to a psychiatrist.

Service leads shared with us many stories of individual staff members of staff going above and beyond their duty to offer support in different ways to patients and their families. One patient’s family had travelled a long distance on a bank holiday and the hospital amenities were closed, so the nurse sent out for toiletries and food from a nearby supermarket to give to the family.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment. People and those close to them were active partners in their care.

Staff always and continually communicated with the patients on decisions. The critical care admission, discharge and escalation policy audit for December 2018 showed that there was 100% compliance by a critical care co-ordinator to inform a patient once a ward bed was allocated to them.

We observed a ward round and saw good interaction with the patient and the plan for treatment was discussed with them.

The unit had access to a specialist nurse organ donor (SNOD) who was assessible to staff on the unit. Staff would identify a patient who was a possibility to become a donor and they would ring the
UK organ donor referral line to assess the suitability of the patient. The SNOD would approach relatives when treatment was being withdrawn to gain consent and offer support.
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

Patients were well supported on transfer or discharge. We spoke to the service improvement lead who arranged the follow-up clinics for patients. All level three critical care patients discharged from the unit were invited to attend the follow up clinics, three to six months after discharge. The clinics were held at the hospital in the doctor’s handover room, however, if the patient felt that they could not return to the unit, arrangements could be made to meet them outside the hospital setting.

The waiting room had a drinks machine and tea and coffee was available for a small charge.

The unit had a private room, in addition to the family waiting room where nurses and doctors supported families in private.

The critical care issued a ‘Steps’ booklet, which was an intensive guide for patients and families. The booklet gave advice and support for discharge from the unit. It was informative advising patient and families on risks and what to expect, for example; preventing infection and behaviours after a lengthy stay. The booklet gave details for a website offering more support.

Delirium leaflets were also available informing patients and families about delirium in intensive care patients.

Meeting people’s individual needs

The service took account of patients’ individual needs.

A recent patient and relative survey showed that people visiting the unit thought that the visiting times were restrictive. As a result, afternoon visiting times were extended by half an hour, from 4pm to 4.30pm.

There was a large, spacious relatives’ room, which we found to be clean and tidy. There was plenty of seating, and a tea and coffee machine. There were magazines, but no TV or radio for the relatives waiting. We were told that the radio had been stolen several times, however, the unit soon hoped to have the hospital radio broadcast.

There was a large toilet for use by visitors to the unit, which had wheelchair assessible. This was also cleaned to a high standard.

The toilet for visitors to the unit, was wheelchair accessible and had a pictorial sign on the door, as did the other toilets on the unit.

Staff were aware of and used ‘This is me’ booklets which are available to be used for patients living with dementia, those with an autism spectrum disorder, or anyone who would benefit. The booklet can be brought in with the patient or started in hospital to support the patient in an unfamiliar place. Examples of questions asked in the booklet; ‘What's important to me’ and ‘Things that may worry or upset me’. We spoke to a nurse who demonstrated that a patient had recently benefited from using the booklet, as staff were made aware that he did not like certain noises, so they took this into consideration to keep them calm.

Access and flow
People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Patients had timely access to initial assessment and were all seen by a critical care consultant within 12 hours of admission.

Trust bed meetings were held four times daily, 8am, 12pm, 3pm and 6pm. The critical care lead nurse attended the 8am bed meeting daily and if possible also attended the 3pm, in order to be fully updated on the bed state and share the capacity for critical care beds.

It was automatically flagged up at the bed meeting if a patient was mobile and waiting for a bed outside critical care. Any delay in patient discharge from critical care beyond four hours caused a mixed sex breach due to the configuration of the unit and there only being one patient toilet. We reviewed the critical care admission, discharge and escalation policy which clearly identified when a breach would be caused; ‘Patients deemed no longer requiring level two care, should be discharged within four hours and must be stepped down within 24 hours of being declared medically fit for step down (avoiding the hours between 10pm to 7am). Patient safety must never be compromised as a result of single sex accommodation requirements.’

The trust had recently updated its discharge policy, which had been shared with the critical care staff and they were aware of it. It was clear and concise and included the admission process and discharge process in critical care.

In the Intensive Care and National Audit and Research Centre report for 1 April-30 September 2018 the service reported 7.6% of bed days of care post 8-hour delay which was similar to than the national average for similar units (7.7%). The service reported 4% of bed days of care post 24-hour delay which was better than the national average for similar units (5%).

We looked at a critical care admission, discharge and escalation policy audit which was conducted by the critical care nurse lead, acute care team matron and the critical care audit clerk. The audit looked at a random sample of 27 admissions, 20 discharges, single sex breaches and the unit compliance for escalation for December 2018. The audit found that six out of 44 discharged patients breached the single sex accommodation standard in December 2018 (86% compliance with standard). One patient was nursed in theatre recovery longer than four hours, prior to admission to critical care due to lack of capacity. The audit was thorough and resulted in a quality improvement action plan. All actions were achieved by 28 February 2019.

The most recent validated ICNARC data for 1 April to 30 September 2018 showed that the unit performed slightly better than similar units for discharges out of hours; Warrington Hospital 1.3%, other similar units 1.4%.

Transfers out to other critical care units were minimal and the most recent ICNARC data showed no transfers out to other critical care units.

Patients were on occasions ‘nursed’ in recovery whilst awaiting a critical care bed, this was in line with an agreed local internal escalation process in line with Cheshire and Mersey Critical Care Network’s Standards for Management of Critical Care Capacity, to avoid non-clinical transfers. If a patient was to stay in theatre recovery due to shortage of beds in critical care, the critical care consultant would still take ownership for the patient. The patient would be nursed by the theatre recovery nurses, and an anaesthetist from critical care. If the patient was nursed in recovery for four hours or more it would be reported as an incident. Patients nursed in recovery were audited and between April 2018 and March 2019 there were only eight patients nursed in theatre recovery whilst awaiting admission to critical care.
Bed occupancy

From December 2017 to November 2018, Warrington and Halton Hospitals NHS Foundation Trust has seen adult bed occupancy similar or higher than the England average. However, in the latest period, November 2018, adult bed occupancy was lower than the England average with 61.1%, compared to 82.7%.

Adult critical care Bed occupancy rates, Warrington and Halton Hospitals NHS Foundation Trust.

Note: Data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Any complaints were looked at ward manager level and then escalated to consultants and if relevant, to critical care leads. We looked at five ongoing complaints for critical care, however they were classed as partial complaints as they involved other services at the trust, with only a handful of queries for critical care. All five complaints showed that the critical care leads had acknowledged their part of the complaint and actioned and responded in a timely manner.

We looked at a complaint from a relative where a patient’s own medicines had gone missing on discharge from critical care to the wards. The investigation revealed that the critical care staff had sent the medicines with the patient’s belongings, but it had been overseen. As a result of learning from this compliant, the discharge check lists were amended to include a medicine handover with the patient’s belongings and the nurse overseeing the transfer and the receiving nurse must now sign accordingly.

We reviewed minutes from the critical care speciality meeting minutes from 19 Dec 2018 and saw that there were no complaints to discuss.

Summary of complaints

From December 2017 to December 2018, there were four complaints about critical care at Warrington Hospital. These were all about patient care. The trust took an average of 21 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 60 working days for high graded complaints and 30
working days for moderate and low graded complaints. The vast majority of complaints are moderate and low grade so the 30 working-day target has been used.

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

**Number of compliments made to the trust**

From January 2018 to December 2018, there were two compliments for the intensive treatment unit (ITU) within critical care at Warrington Hospital.

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

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Leaders had the skills, knowledge, experience and integrity to lead the service.

Staff told us that leadership team were visible and approachable.

Mechanisms were in place for providing all staff at every level with the development they needed, including quality appraisals and career development.

The unit had a designated critical care lead consultant and a critical care lead nurse. We met with the leads for critical care who worked well together and interacted with each other appropriately.

The critical care lead nurse was responsible for the nursing elements of the service and was visible on the wards.

A critical care admission, discharge and escalation policy audit for was carried out in December 2018, by the critical care lead nurse, ACT Matron and the care audit clerk. The audit looked at the number of delayed discharges from critical care, the lack of a formal escalation policy and the number of mixed sex accommodation breaches.

Critical care leads emailed staff once a month with ‘Pit stop’ which was any highlights, or topical issues, a recent ‘Pit stop’ had been to reiterate sepsis and embed knowledge.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The unit’s values were clear and were the same as the trust values; working together, excellence, accountable, role model and embracing change. They were displayed around the unit so that staff were familiar with them.

The unit’s vision was to be ‘Outstanding’ and this and their mission statement; ‘Better people make patients better’ was displayed in all areas for staff and patients to see.

The unit only had two isolation rooms, which was recorded on the unit’s risk register. Leads told us that the vision for the unit was to transform two current bays (15 and 16) in the main unit into isolation rooms and a currently unoccupied space into a patient wet room. Minutes of the ICU management meeting on 20 March 2019 minuted that the bid to convert the bed spaces into single rooms had been withdrawn due to the estate’s quotation increasing significantly.

Seven new staff had been appointed to roles within ICU and were due to start next month.

The unit had used charitable funds to purchase equipment for the unit and had plans to convert an unused roof top leading off from the unit, into a roof top garden for long term patients to be taken out safely for fresh air. Staff on the unit had worked together to develop the ideas of what the garden should look like and how patients could benefit from it.
Culture
Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff felt supported, respected and valued. The service had its own employee of the month, which was awarded to a member of staff with a certificate and gift as recognition.

Senior band five nurses were placed on a rotation to be attached to the outreach team. This promoted multidisciplinary team working and helped retention of staff for the unit. The nurses would complete a three-month attachment.

We spoke to junior doctors who said they felt supported by the consultants and it was a good place to work to undertake specialist training.

A representative from the unit attended the daily, morning trust safety brief and at the end of the brief all departments were asked for any ‘Bright Spots’, this was the opportunity for the managers on the unit to highlight and share, good work from their unit, with the rest of the trust.

Consultants worked well to support each other and all shared each other’s contact numbers in order to contact for help and advice out of hours. They had also created a closed social media group after the recent terrorist attack in Manchester, in order to get messages direct to each other and share information instantly.

We were told that the staff in critical care were a ‘close knit’ team and supported each other well. Any celebrations were shared, and all staff contributed to celebration buffets.

Governance
The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There was an identifiable supernumerary clinical co-ordinator in every shift.

The outreach team were an integral part of the unit and was manged in accordance with the principles in Guidelines for the Provision of Intensive Care Services (2015). The outreach reach team was a multidisciplinary organisational approach which cared for acutely unwell, critically ill and recovering patients, irrespective of location or pathway.

The unit had a band five infection control nurse who acted as the sepsis lead overseeing the unit’s sepsis management.

A unit meeting took place every two months, for all staff to attend, where incidents would also be shared, however this was not well attended. Mangers told us this was due to staff not able to attend on the rest days and due to busy times on the unit, staff were unable to be released to attend.

The critical care leads attended a monthly speciality governance meeting where incidents were discussed together with; the critical care risk register, any ongoing root cause analysis investigations, dashboards, corners inquests, complaints and performance. We looked at the critical care speciality meeting minutes for three months and saw evidence of this.

In addition to the governance meeting, critical care leads attended; a monthly nursing and midwifery forum and a monthly patient safety clinical effectiveness meeting.
A monthly MDT meeting also took place and was well attended by critical care managers and leads.

A business meeting took place every Friday for critical care which shared incident and learning across different disciplines, including physiotherapists and pharmacy.

The medical advisory committee fed into the medical clinical directors meeting, which in turn fed into the specialty governance multidisciplinary governance meeting. This looked at audits and included quality improvements.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. We looked at three months of minutes and action notes for the critical care speciality meeting which looked at high risk and moderate risks, for the meeting in February 2019 there had been no new risks for two months.

The critical care unit had a comprehensive risk register which identified the risk, owner, actions and completion date. We spoke to the critical care leads who listed the units top five risks which were in alignment to those recorded on the risk register.

In addition to the sepsis lead the unit had recently filled the new position of a patient safety nurse.

The service had back up emergency generators in case of failure of essential services. Staff we spoke to knew of the evacuation procedure although only the band seven nurses appeared to have taken part in any table top exercise and no one appeared to have been part of a mock evacuation drill. We did however see guidance for escalation information displayed on the unit, which informed staff of how to review the acuity of patients in order to consider moving them.

The critical care admission, discharge and escalation policy had guidance documents embedded in the policy for staff to refer to, which included; the North West adult critical care network’s escalation guidance for local critical care capacity pressures and the NHS major contingencies guidance for critical care escalation 2018. Both were comprehensive and up to date.

**Information management**

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

There were effective arrangements to ensure that data or notifications were submitted to external bodies. The unit took part in local and national audits, including the Intensive Care National Audit and Research Centre (ICNARC). The unit had a dedicated ICNARC clerk who collated all relevant information and submitted the evidence to ICNARC every quarter.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
Peoples views and experiences were gathered and acted on to shape and improve the services and culture.

Feedback forms were given to attendees of both the critical care follow-up clinics and the support groups to provide feedback to the unit.

A relatives’ satisfaction survey was conducted twice a year, we saw the results from the last survey, collated from between October 2018 and February 2019. Negative comments were acted upon in a timely manner. An example was a comment made with regards to the décor being drab in the waiting room. The unit acted upon this and has secured funding from charitable donations for a large critical illness pathway interactive poster which would be erected to cover the wall in the waiting room. The poster had been developed as an interactive tool that provided a detailed overview of the most common aspects of critical illness and the journey that patients and families could potentially encounter.

A wallpaper mural effect of a bluebell wood had also been ordered to cover a wall in the counselling room to provide a calming restful feature that detracts from the clinical environment.

Staff were actively engaged and their views were reflected in the planning and delivery of services. A ‘Dragons Den’ style project had taken place recently on the unit, encouraging staff to put forward ideas on how to spend money in the unit, from a large charitable donation.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

In the handover/conference room on the unit we saw a wall full of awards for the unit and personal staff achievements. The staff were very proud of their ‘wall’ and had each certificate framed to display. Some recent awards included; 2017 the unit was a finalist in intensive care nurses eliminating infection, 2018 the unit won an award for development of the ICU patient satisfactory survey and 2019 the unit was a finalist for patient safety and innovation for their work on implementing NEWS(2).

The critical care staff also participated in working party groups, which included the rehabilitation working party, every eight weeks. This was attended by representatives from the unit. The service improvement lead attended this together with a physiotherapist, looking at universal provisions across the network. Recently the unit had shared their experience of patient diaries with the network and patient psychological support.

Critical care had trialled an electrical device to aid immobile patients and a specialist rehabilitation chair, prior to submitting charitable funds to purchase them for the unit. The bids were approved on 7 March 2019 for the electric device and two specialist chairs, which we saw evidence of. The electrical device is a motor-assisted therapy of either the upper or lower limbs. Providing the patient with the opportunity to benefit from therapy, which has physical and psychological benefits. The chairs would assist patients who experienced severe muscle wasting from critical illness which was exacerbated by prolonged periods of bed rest.

The acute care team won a Northwest Coast Innovation Awards 2019 for the implementation of NEWS(2). Following guidance from the Royal College of Physicians (RCOP 2017) and the NHSI Patient Safety Alert, the trust was keen to implement the standardised, evidence-based process for recording, scoring and responding physiological parameters in adults NEWS2. This was to
ensure earlier recognition and better identification of those patients presenting with an acute illness. Their clinically led approach, ensured staff engagement, training, education and board level assurance of progress against the implementation plan. Being one of the first acute trusts to implement the change, the trust then shared their experience to support safe implementation to other organisations.

We saw a list of quality improvement projects which stated the lead for the project, when it was started, the requirement and completion date, for example; to start a critical care simulation programme. This had started in October 2018.

The unit was an active member of the Cheshire and Mersey adult critical care operational delivery network. Network meetings took place quarterly, attended by the critical care service improvement lead and lead clinician. They reviewed all serious incidents and shared lessons to improve safety.
Maternity

Facts and data about this service

The trust maternity service offers a range of services and choices. The service works in collaboration with other maternity care providers, including the independent sector, to ensure seamless care and is able to offer choices of location for antenatal care within the community and hospital, along with antenatal education, post-dates clinics, aromatherapy, acupuncture and hypnobirthing.

The service provides midwifery led care for women who have no complications, including an option to birth at home or in the midwifery led unit - cared for by a team of midwives throughout their journey. The service provides complex care for women with complicated pregnancies, supported by an obstetric team and specialist midwives.

The labour ward is equipped with monitoring technology but also provides mats and balls to support normal physiology throughout labour and birth. The consultant midwife provides support to women requiring bespoke care and supports birth planning in collaboration with obstetricians and midwives.

Women and their families can go straight home from the midwifery led unit or labour ward if both are well, but if not, further care is provided on ward C23, the antenatal and postnatal ward. Transitional care is also located here, which provides extra care to babies who require it. Partners can stay with women throughout their experience in the midwifery led unit, labour ward or the ward. Continuity of care models are currently being developed to improve women and their families experience, as well as improve outcomes.

(Source: Routine Provider Information Request (RPIR) – Acute Context tab)

The service also includes a triage area, an antenatal day unit and an antenatal clinic.

From October 2017 to September 2018 there were 2,649 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at Warrington and Halton Hospitals NHS Foundation Trust – Comparison with other trusts in England
A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below.

<table>
<thead>
<tr>
<th>Profile of all deliveries (April 2017 to March 2018)</th>
<th>WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2,563</td>
<td>98.6%</td>
</tr>
<tr>
<td>Multiple</td>
<td>37</td>
<td>1.4%</td>
</tr>
<tr>
<td>Mother's age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>94</td>
<td>3.6%</td>
</tr>
<tr>
<td>20-34</td>
<td>2,024</td>
<td>77.8%</td>
</tr>
<tr>
<td>35-39</td>
<td>399</td>
<td>15.3%</td>
</tr>
<tr>
<td>40+</td>
<td>83</td>
<td>3.2%</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,600</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is "other" or "unrecorded".
The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

**Number of deliveries at Warrington and Halton Hospitals NHS Foundation Trust by quarter**

![Graph showing number of deliveries by quarter](image)

Over the two year's there was a steady trend in the number of deliveries per quarter, with the lowest levels showing from April 2017 to June 2017 (588), and the highest levels the following quarter, July 2017 to September 2017 (727).

(Source: Hospital Episode Statistics - HES Deliveries (April 2016 - September 2018))
Is the service safe?

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

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training. The below data analysis includes some staff working across both maternity and gynaecology.

The service provided mandatory training in key skills to all staff and made sure everyone completed it. All training was multi-disciplinary with doctors and midwives attending.

A learning development midwife monitored the training needs of the service. Training included face to face and e-learning modules. The training programme was multidisciplinary and included obstetricians, midwives, anaesthetists and health care assistants.

Quarterly assurance reports were completed to monitor compliance with mandatory training.

Simulations were carried out for obstetric and neonatal emergencies to enhance training and monitor competencies.

Warrington Hospital

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 at Warrington Hospital for qualified nursing and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>23</td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>22</td>
</tr>
<tr>
<td>Medicines management awareness - No renewal</td>
<td>19</td>
</tr>
<tr>
<td>Infection prevention and control - level 1 - 3 years</td>
<td>1</td>
</tr>
<tr>
<td>Moving and handling - level 1 - 3 years</td>
<td>4</td>
</tr>
<tr>
<td>Counter fraud - no renewal</td>
<td>22</td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>20</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>19</td>
</tr>
<tr>
<td>Falls awareness and post falls pathway - 3 years</td>
<td>18</td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>17</td>
</tr>
</tbody>
</table>
In maternity the 85% target was met for 14 of the 15 mandatory training modules for which qualified midwifery staff were eligible. Of these, five mandatory courses had 100% completion rate. The information governance training module did not meet the trust target with 83.3% completion rate.

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 at Warrington Hospital for medical staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>7</td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>7</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - No renewal</td>
<td>1</td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>1</td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>7</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>1</td>
</tr>
<tr>
<td>Falls awareness and post falls pathway - 3 years</td>
<td>6</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>1</td>
</tr>
<tr>
<td>Infection prevention and control - level 2 - 1 year</td>
<td>8</td>
</tr>
<tr>
<td>NHS conflict resolution (England) - 3 years</td>
<td>1</td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>7</td>
</tr>
<tr>
<td>Resus level 2</td>
<td>6</td>
</tr>
<tr>
<td>Counter fraud - No renewal</td>
<td>5</td>
</tr>
<tr>
<td>Medicines management awareness - No renewal</td>
<td>0</td>
</tr>
<tr>
<td>Moving and handling - level 1 - 3 years</td>
<td>0</td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for 12 of the 15 mandatory training modules for which medical staff were eligible. Of these, 10 mandatory courses had 100% completion rate, although this was based on low numbers of eligible medical staff. Performance should be taken in context when dealing with small numbers of eligible staff.
Following the inspection mandatory training compliance data from the trust showed that for midwives the overall compliance was 92.6% and for medical staff 95.2%:

**Safeguarding**

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff were compliant with safeguarding level three training for children.

Safeguarding training included female genital mutilation and child sex exploitation.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training. The below data analysis includes some staff working across both maternity and gynaecology.

**Warrington Hospital**

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 at Warrington Hospital for qualified nursing and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to December 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>22</td>
<td>22</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 3 - 3 years</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>18</td>
<td>18</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>17</td>
<td>18</td>
<td>94.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>16</td>
<td>18</td>
<td>88.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In maternity the 85% target was met for all of the seven safeguarding training modules for which qualified midwifery staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 at Warrington Hospital for medical staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to December 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Preventing radicalisation - levels 1 & 2 (Basic prevent)

<table>
<thead>
<tr>
<th></th>
<th>7</th>
<th>7</th>
<th>100%</th>
<th>85%</th>
<th>Yes</th>
</tr>
</thead>
</table>

Safeguarding adults - level 2 - 3 years

<table>
<thead>
<tr>
<th></th>
<th>7</th>
<th>7</th>
<th>100%</th>
<th>85%</th>
<th>Yes</th>
</tr>
</thead>
</table>

Safeguarding children - level 2 - 3 years

<table>
<thead>
<tr>
<th></th>
<th>6</th>
<th>7</th>
<th>85.7%</th>
<th>85%</th>
<th>Yes</th>
</tr>
</thead>
</table>

Safeguarding children (Version 2) - level 1 - 3 years

<table>
<thead>
<tr>
<th></th>
<th>6</th>
<th>7</th>
<th>85.7%</th>
<th>85%</th>
<th>Yes</th>
</tr>
</thead>
</table>

Safeguarding children - level 3 - 3 years

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>0.0%</th>
<th>85%</th>
<th>No</th>
</tr>
</thead>
</table>

Preventing radicalisation - levels 3, 4 & 5 (Prevent awareness)

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>0.0%</th>
<th>85%</th>
<th>No</th>
</tr>
</thead>
</table>

In maternity the 85% target was met for five of the seven safeguarding training modules for which medical staff were eligible. Two modules had a 0% completion rate although this was based on only one eligible medical staff member not completing the course. Performance should be taken in context when dealing with small numbers of eligible staff.

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

Following the inspection, data from the trust showed that 100% of eligible medical staff had completed safeguarding level 3 training for children and 93.3% had completed safeguarding level 3 training for adults. 97.9% of eligible midwives had completed safeguarding level 3 training for children and 57.9% of eligible midwives had completed safeguarding level 3 training for adults.

The trust confirmed that there was a midwife available who had received safeguarding adults level three training to cover each shift. The overall compliance in this group was 92%.

For the specialist midwives, band seven or above, the current compliance was 50% with a trajectory of 100% compliance by 30 June 2019.

The trust had safeguarding policies and procedures in place and there was a safeguarding midwife that could provide guidance and support to staff.

Patient paper and electronic records were organised so that any woman with a concern was easily identified by staff.

Staff accessed the wards with photo identification badges. Visitors were required to press a buzzer to request entry. Cameras were positioned at each entry point with staff positioned on reception desks monitoring access to the wards. We were told that security was alerted to any individual not usually permitted on the ward (such as for a safeguarding concern about a visitor).

Parents were encouraged to stay with their baby, including posters to remind parents.

Cleanliness, infection control and hygiene

Staff controlled infection risk well. All ward and obstetric theatre areas inspected were visibly clean and cleaning rotas were in place.

All ward and obstetric theatre areas inspected were visibly clean and cleaning rotas were in place and completed.

There had been no incidents of clostridium difficile between December 2017 and November 2018.
There were wall-mounted handwashing gel/solutions at clinical sinks with handwashing instructions. Hand gels and personal protective equipment such as gloves and aprons, were adequately stocked in all areas.

We observed staff adhering to ‘arms bare below the elbows’ guidance and washing hands prior to patient contact as well as a reminder to staff during a medical handover.

We observed cleaning schedules including evidence of legionella testing in bathroom areas.

Staff followed the correct dress code and gowned procedures in theatre areas, although outdoor footwear was not changed between corridors and main theatres.

The privacy curtains in ward and outpatient areas were all disposable and all dated as changed within the last six months.

The sharps bins we saw were not over filled and were being used appropriately. We observed that all clinical waste was disposed of appropriately including pregnancy remains.

Any clinical waste, in the community, was taken back to the hospital by the community midwife, for disposal.

There were processes for women to receive vaccinations for pertussis and influenza, with midwives in the antenatal clinic administering antenatally if required.

Monthly audits of hand hygiene, uniforms and environment were carried at the service. Between May 2018 and February 2019. There was 100% compliance with uniform / workwear and hygiene on the maternity ward and the labour ward. Environmental audits ranged between 88% and 98% for the maternity ward, between 90% and 100% for labour ward and between 91% and 100% for the midwifery led unit.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

The maternity unit had a dedicated entrance that could be accessed anytime. The door was locked overnight, between 10pm and 6am, but there was a buzzer that was linked to the labour ward. There was an area outside suitable for an ambulance and the entrance was close to car parks.

At the time of inspection, planned maintenance work was in progress in the maternity theatres. This meant that elective caesarean sections were taking place in the main theatres. There was clear signage, in the corridors, to direct visitors. Emergency caesarean sections continued in one of the two labour ward theatres.

The labour ward included two admission rooms and five high risk delivery rooms, of which one was for enhanced care. There was also an alongside midwifery led unit that included three rooms, two of which had fixed pools.

The neonatal unit was located next to the maternity ward. Staff told us that all babies were transferred on resuscitaires. (A resuscitaire was a warming platform for babies, along with equipment needed for emergency and resuscitation.)

The induction of labour bay was situated outside of the labour ward, next to the maternity ward. Since the last inspection, call bells had been installed for women to use as well as a dedicated midwife assigned to the bay. Beds, in this area, had been reduced from six to five to provide space for equipment such as birthing balls for women. In outpatient areas, the triage area included call
bells and two treatment rooms included call bells. The consulting and examination rooms did not include call bells but all included phones with the emergency number visible.

The bereavement suite was a spacious bright area located away from other delivery rooms. There were two rooms that had been recently decorated in calming colours, one with a hospital bed and the other with a double bed. Both had kitchen and seating areas as well as cribs providing a homely rather than clinical environment.

The maternity ward included women receiving antenatal care and postnatal care. There were three bays of six beds and three side rooms. The bay at the furthest from the nurses’ station was generally occupied by women receiving antenatal care. Each bed space included access to piped oxygen and suction.

The bay opposite the nurses’ station was also used for transitional care. This meant that babies who needed extra care, such as antibiotics, could remain on the ward with their parents. Staff from the neonatal unit visited the ward to administer the antibiotics, although the service was looking at future plans for midwives to be trained to administer.

Following the last inspection, a dedicated triage area was created along with an antenatal day unit. The planned opening hours for this area was 8am until 8pm, seven days a week, however; due to long-term sickness, it had been closing at 6pm. Plans were in place to extend the hours in the near future. The antenatal day unit, that had one bed, saw women who required additional planned monitoring, using an appointment system. The triage area included four recliner chairs where routine monitoring could take place and another room with four beds used for examinations and also monitoring, such as cardiotography, that recorded the fetal heart rate.

The antenatal clinic was across from the triage area, on the ground floor. Since the last inspection, there had been some changes in clinic provision with the invitro fertilization clinics being transferred to Halton hospital. Women were encouraged to enter by a dedicated entrance for antenatal care, reception area and seating area, away from the gynaecology waiting area. Following fund raising events, a mural of bluebell flowers had been planned for the antenatal clinic walls.

The community midwives had their office base on the unit, although clinics were held in children’s centres in localities attached to GPs. Birthing packs were stored securely, including medical gases.

Community midwives carried bilirubinometers (a device that measures the amount of bilirubin in the blood. This can make babies appear yellow in colour). This meant that they could check babies as well as observational checks in line with National Institute for Health and Care Excellence guidance.

Daily checks of equipment were completed and recorded in a file with detailed checklists. These were all completed appropriately. All scales had been calibrated within the last 12 months.

Following the inspection, the trust confirmed that competencies for midwives included medical devices as below:

<table>
<thead>
<tr>
<th></th>
<th>Total required</th>
<th>Total achieved</th>
<th>% of competency achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal Day Unit</td>
<td>199</td>
<td>199</td>
<td>100%</td>
</tr>
<tr>
<td>Ward C23 (maternity)</td>
<td>560</td>
<td>504</td>
<td>90%</td>
</tr>
</tbody>
</table>

Warrington and Halton Hospitals NHS Foundation Trust Evidence Appendix July 2019
Community midwives 366 318 87%
Labour ward 2175 1232 87%

Assessing and responding to patient risk

Risk assessments were carried out for women to identify care and treatment needs.

Paper risk assessments were completed at the time of booking, to assess the level of risk for the woman during the pregnancy. These included: previous history, risk of venous thromboembolism, and carbon monoxide testing as well as social and mental health wellbeing. The service participated in the perinatal institute’s Growth Assessment Project programme which monitored the growth of babies in utero, with particular attention to smaller babies. A dedicated midwife sonographer, based alongside the antenatal day unit, monitored babies included in this programme. The level of risks identified determined any need for referral to an obstetrician.

In the community, an environmental risk assessment was carried out to ensure the safety of the midwives as well as the woman and baby.

Any woman initially assessed as low risk who became high risk was cared for on the labour ward as well as any woman not booked at the hospital, in labour, would be considered as high risk and therefore seen on the labour ward.

There was a process for directing women who presented at the accident and emergency department. Depending on how imminent the birth was, the department liaised with the labour ward and the woman was escorted to maternity services. Otherwise birth packs and equipment was available in the accident and emergency department if needed.

The service told us there was always one to one care in labour and delivery. Information provided by the service showed that between December 2017 and November 2018, there was one to one care in established labour an average of 98% of time.

Midwives used cardiotocography to monitor women. This included the ‘fresh eyes approach’ where another midwife checks the monitoring for accuracy and supports the midwife providing the one to one care. This was carried out hourly as per the trust policy.

If a woman required intensive monitoring they could be transferred to the critical care unit following outreach review.

Diabetes was monitored throughout pregnancy and postnatally. The trust endocrinologist supported specialist antenatal clinics when required.

The labour ward included two dedicated maternity theatres for a combination of planned and caesarean section operations. We observed a theatre briefing prior to surgery commencing. We then observed an obstetric theatre team undertaking the World Health Organisation maternity five steps to safety surgery checklist, including online, during a caesarean section operation. We observed that this was completed appropriately. Since the last inspection, the trust had introduced an enhanced recovery programme for elective caesarean sections. This included a dedicated midwife supporting the woman, and her partner antenatally, preoperatively, during the surgery and post-operatively providing continuity of care.

The safety surgical checklist was completed electronically. Data from the trust showed that between April 2018 and March 2018, there was 99% compliance with the process.
The midwifery led unit included two birthing pools, although there was only one net in case of a need for emergency evacuation. We were told that is was unusual that both pools were in use at the same time.

Staff used the modified early obstetric warning score system when monitoring women. This system allows early recognition of physical deterioration by close monitoring of vital signs of women receiving maternity care. An audit of the scoring system between March 2018 and February 2019, showed that 100% of staff had the skills to check vital signs. There was 100% of scores that had been completed appropriately as well as 100% escalation when applicable. A baby early warning score system was used for monitoring babies. An electronic system had been introduced that displayed patient information including ‘flags’ to remind staff of additional details to be aware of. There were plans to link this system to recording of observations in order to prevent any delays in escalating concerns.

Packs were available on the maternity ward and antenatal areas in the event of an emergency such as a sepsis and a hypoglycaemia (low blood sugar) box.

Following the inspection, resuscitation training compliance data from the trust showed that compliance with adult resuscitation was 69% and 94% for newborn life support for medical staff. For midwives, compliance was 94% for adult resuscitation and 90% for newborn life support.

The trust confirmed that there was always a medical staff member trained in adult resuscitation as below:

<table>
<thead>
<tr>
<th></th>
<th>*Obstetricians</th>
<th>Obstetric anaesthetists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult resuscitation</td>
<td>consultant grades – 85%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>ST3 and above – 100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>overall compliance – 94%</td>
<td></td>
</tr>
</tbody>
</table>

*Includes obstetric consultants and ST3 and above who cover the obstetric rota.

**Midwifery and nurse staffing**

**Planned vs actual**

The service had enough staff with the right qualifications, skills, training and experience to keep women safe to provide the right care and treatment. Since the last inspection, there was one-to-one care in labour with a supernumerary co-ordinator as well as manager of the week. There was 60 hours consultant cover per month.

The trust has reported their nursing and midwifery staffing numbers below, by ward, from April 2017 to March 2018 and from April to November 2018 in maternity. The service had a fill rate of 93.9% from April 2017 to March 2018, and a fill rate of 91.5% from April to November 2018.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Ante-natal day unit</td>
<td>12.2</td>
<td>11.3</td>
</tr>
<tr>
<td>Labour ward</td>
<td>46.6</td>
<td>46.0</td>
</tr>
<tr>
<td>Ward C23</td>
<td>17.7</td>
<td>14.6</td>
</tr>
</tbody>
</table>
There were processes in place to ensure sufficient numbers of trained midwifery and support staff in ward areas and theatres to provide safe care and treatment.

A noticeboard displayed the expected and actual numbers of midwifery and nursing staffing levels on the labour ward and the maternity ward.

Staff worked either as core staff in a designated area or on a rotational basis between labour ward, the maternity ward and antenatal. They also rotated between day and night shifts. A staffing acuity tool was used: birthrate plus to ensure safe levels for the service. A staffing ‘red flag’ system was also in place as per the National Institute for Health and Care Excellence (NICE) guideline NG4: Safe midwifery staffing for maternity settings.

Noticeboards displayed the actual and expected staffing on a daily basis as well as posters to identify the grades of staff present.

We observed midwifery handovers on the labour ward and the maternity ward. These took place when staff began a shift and included clear concise verbal and written information about women. Handovers also included sharing of information such as reminders about policies.

The matrons and ward managers attended a safety huddle daily to monitor staffing and acuity of women to ensure appropriate care and treatment throughout the unit. Further huddles were planned if, and when, needed during the day.

The labour ward co-ordinator was supernumerary to the midwives allocated to women and could, therefore support the midwives as needed as have oversight. There was also a manager of the day, on a rota system, where a senior manager was available with oversight of the maternity service.

The community midwives were allocated women as their named midwives. These worked in teams to help promote continuity for women in line with the Better Births: Improving outcomes of maternity services in England recommendations. This meant that either the named midwife or a member of the team should be in contact with women both antenatally and postnatally.

There was a preceptorship programme, for newly-qualified midwives, of 18 to 24 months, that included orientation to all areas and a competency pack to complete. They were supported with group meetings and reflection.

**Vacancy rates**

Following the inspection, data from the trust showed that:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Funded FTE</th>
<th>Actual FTE</th>
<th>Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>18.51</td>
<td>17.96</td>
<td>2.97%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>3.65</td>
<td>4.45</td>
<td>-22.01%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>2</td>
<td>2</td>
<td>0.00%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>29.86</td>
<td>27.85</td>
<td>6.73%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>74.62</td>
<td>72.17</td>
<td>3.27%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>128.64</strong></td>
<td><strong>124.44</strong></td>
<td><strong>3.26%</strong></td>
</tr>
</tbody>
</table>

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

From December 2017 to November 2018, Warrington Hospital reported a turnover rate of 5.4% for qualified nursing and midwifery staff in maternity. This was lower than the trust target of 13%.

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

Sickness rates

From December 2017 to November 2018, Warrington Hospital reported a sickness rate of 6.3% for qualified nursing and midwifery staff in maternity. This was higher than the trust target of 4.3%.

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

In the triage and antenatal day unit, long-term sickness resulted in temporarily revising the opening hours to 6pm closure, however; plans were in place to increase to 8pm when staff had returned from sick leave.

Bank and agency staff usage

Warrington Hospital

From December 2017 to November 2018, the trust reported 11,281 (7.8%) bank hours and no agency hours were filled by qualified nursing and midwifery staff in maternity at Warrington Hospital. There were 4,098 hours (2.8%) that were left unfilled.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Site/ward</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Ante-natal day unit</td>
<td>23,352</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Labour ward</td>
<td>87,070</td>
<td>8,164</td>
<td>9.4%</td>
</tr>
<tr>
<td>Ward C23</td>
<td>33,928</td>
<td>3,117</td>
<td>9.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>144,349</strong></td>
<td><strong>11,281</strong></td>
<td><strong>7.8%</strong></td>
</tr>
</tbody>
</table>

During the same period, the trust reported 5,156 (14.6%) bank hours and no agency hours were filled by nursing assistants in maternity at Warrington Hospital. There were 2,838 hours (8.0%) that were left unfilled.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Site/ward</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Ante-natal day unit</td>
<td>7,650</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Labour ward</td>
<td>10,308</td>
<td>2,224</td>
<td>21.6%</td>
</tr>
<tr>
<td>Ward C23</td>
<td>17,442</td>
<td>2,932</td>
<td>16.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35,400</strong></td>
<td><strong>5,156</strong></td>
<td><strong>14.6%</strong></td>
</tr>
</tbody>
</table>
The trust reports that it “continues to strive to reduce bank and agency reliance for all services. Non-qualified nurse agency spend is almost non-existent and bank usage is tackled through our recruitment drives to fill our vacancies.”

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

At the time of inspection, we were told that any shortfalls in staffing due to short-term sickness were supplemented by the midwifery bank that included registered midwives and health care assistants who were familiar with the unit.

Midwife to birth ratio

From July 2017 to June 2018, the trust had a ratio of one midwife to every 26.4 births. This was similar to the England average of one midwife to every 25.5 births.

(Source: Electronic Staff Records – EST Data Warehouse)

Between December 2017 and November 2018, the ratio of midwives to birth was one to 29. The safe staffing review reported to the board, in February 2019, showed that using the birthrate plus acuity tool, as recommended by National Quality Board, the ratio was one to 28 at the time of inspection.

Medical staffing

Planned vs actual

The trust has reported their medical staffing numbers below from April 2017 to March 2018 and from April to November 2018 in maternity. The service had a fill rate of 48.7% from March 2017 to April 2018 and remained similar in the more recent period with a fill rate of 49.0%.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>As at March 2018</th>
<th>As at November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Labour ward</td>
<td>27.9</td>
<td>13.6</td>
</tr>
</tbody>
</table>

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

Doctors we spoke with felt there were sufficient numbers of obstetric medical staff for the demands of the service.

Between January 2018 and December 2018, there was an average of 60 hours consultant cover per month on the labour ward.

Data from the trust showed that there were 45 hours of dedicated consultant anaesthetist cover from Monday to Friday between 8am and 5pm. A second obstetric anaesthetist was available to cover maternity services 24 hours per day. The only exception to this was on a Wednesday from
8am to 5pm, when there were no planned elective caesarean sections. In this case, the consultant anaesthetist covered the service.

Additional anaesthetic assistants could be contacted via the consultant anaesthetist covering emergencies.

There was a consultant on-call (non-resident) from 5pm to 8am who could be contacted to assist the obstetric anaesthetist if needed.

We observed a medical handover. The handover was attended by the appropriate staff and all women were discussed using a printed handover record to ensure key information was shared.

**Vacancy rates**

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

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Funded FTE</th>
<th>Actual FTE</th>
<th>Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>29.86</td>
<td>27.85</td>
<td>6.73%</td>
</tr>
</tbody>
</table>

**Turnover rates**

From December 2017 to November 2018, Warrington Hospital reported a turnover rate of 7.4% in maternity. This was lower than the trust target of 13%.

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

**Sickness rates**

From December 2017 to November 2018, Warrington Hospital reported a sickness rate of 0.9% in maternity. This was lower than the trust target of 4.3%.

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

**Bank and locum staff usage**

**Warrington Hospital**

From December 2017 to November 2018, the trust reported 2,008 (3.8%) bank hours and 2,375 (4.5%) locum hours were filled by medical staff in maternity at Warrington Hospital. There were 40 (0.1%) hours that were not filled by bank/locum staff.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Site/ward</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Locum Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour ward</td>
<td>52,938</td>
<td>2,008</td>
<td>2,375</td>
<td>40</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hrs</th>
<th>%</th>
<th>Hrs</th>
<th>%</th>
<th>Hrs</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,008</td>
<td>3.8%</td>
<td>2,375</td>
<td>4.5%</td>
<td>40</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

The trust reported an additional 19,029 central bank hours worked which were not able to associate with a specific speciality.
Staffing skill mix

In October 2018, the proportion of consultant staff and the proportion of junior (foundation year 1-2) staff reported to be working at the trust were both slightly lower than the England average.

Staffing skill mix for the 25.7 whole time equivalent staff working in maternity at Warrington and Halton Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th>Staffing Category</th>
<th>This Trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>38%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>50%</td>
<td>46%</td>
</tr>
<tr>
<td>Junior*</td>
<td>4%</td>
<td>6%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

Records

Staff kept appropriate records of patients’ care and treatment. Since the last inspection, records were stored securely in lockable cabinets. They were clear, up-to-date and available to all staff providing care.

Midwifery care records were a combination of electronic and paper records divided into antenatal, intrapartum and post-natal. Medical staff recorded care in paper clinical records.

Since the last inspection, paper clinical records were stored securely either in lockable trolleys or areas only accessed by authorised staff. We looked at the care records for six patients and found they were structured, legible, and up to date.

Any patients identified as vulnerable was highlighted in the electronic record system.

We reviewed records for eight patients and found that they had been completed and updated appropriately including women with perinatal mental health needs.

Risk assessments were completed for patients as part of their maternity bundle of care. Patient records showed that assessments were carried out before, during and post-delivery and that these were documented appropriately.

We observed that records of women who had received antenatal care from a different provider included some records in different formats. For example, there was no evidence of the venous
thromboembolism form present, although we were shown that these were carried out and recorded on the trust’s electronic system when admitted to the service.

In the community, staff accessed electronic systems on their electronic tablets which meant they could view results of women’s investigations such as blood tests.

The discharge process included a checklist to ensure that all checks were completed prior to the woman leaving the unit. Copies of paperwork were forwarded to GPs and health visitors as well as for the parents and midwives. Red books were given to parents to record the babies’ health and development.

On discharge from community midwifery services, notes were returned to the hospital and filed for storage.

Monthly records audits carried out between March 2018 and February 2019 were carried out both on the maternity ward and labour ward.

<table>
<thead>
<tr>
<th>Question</th>
<th>Maternity ward C23 (average)</th>
<th>Labour ward (average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient records (paper &amp; computer screen) are obscured from view</td>
<td>82%</td>
<td>100%</td>
</tr>
<tr>
<td>Patient identifiable data is stored securely and confidentiality maintained</td>
<td>82%</td>
<td>97%</td>
</tr>
<tr>
<td>Patient assessment documents are completed within 6 hours of admission</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>All documentation in relation to this admission is available and fully completed</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Full set of medical records are available before medical review</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Nursing/Midwifery records are completed to correct standard and contemporaneously</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td>Nursing/Midwifery care plans are personalised and relevant</td>
<td>97%</td>
<td>99%</td>
</tr>
<tr>
<td>Information is recorded in professional and informative manner</td>
<td>97%</td>
<td>100%</td>
</tr>
<tr>
<td>Staff log in details are kept secure and not shared</td>
<td>99%</td>
<td>100%</td>
</tr>
</tbody>
</table>

A further records audit was completed in March 2019. The results showed that all the antenatal standards and the basic note keeping standards were met. For intrapartum care, staff needed to complete the fresh eyes stickers appropriately as well as fluid charts. For postnatal women who were discharged out of area, this needed to be recorded in all cases.
Medicines
The service prescribed, gave, recorded and stored medicines well. Paper prescriptions records were in place including allergy details.

We reviewed prescription records for six patients and found they had been completed appropriately. Paper prescription records were in use, which included details of any allergies.

Medicines, including intravenous fluids, were stored securely and access was restricted to authorised staff. Controlled drugs were managed appropriately and accurate records were maintained.

Portable oxygen cylinders were present and accessible, in all areas and secured with a chain that could be easily removed in the event of an emergency.

Medical gases for homebirths were stored in a secure room. They were transported in midwives’ vehicles when needed, in carrying cases, along with signage for the vehicle. Of the two midwives identified as on call, the first had a supply that was supplemented by the second midwife on their arrival. The midwives carried a vial of oxytocin, along with their obstetric bags. This medicine had a shelf-life when not refrigerated. The team’s medicines were monitored and alerted when this needed to be discarded and replaced.

In the antenatal clinic, patient group directions were maintained for medicines including vaccinations of pertussis and influenza. We observed two template versions; these were being standardised to prevent any confusion regarding authorising signatures. We observed a sealed anaphylaxis box that was available in the event of a reaction.

A patient group direction is medicine that can be administered by a practitioner when it has been signed by a doctor and agreed by a pharmacist, without needing to refer back to a doctor for an individual prescription.

Discharge medicines were available, including in the triage area.

Incidents
The service managed women safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. Staff understood the term duty of candour and when to apply it.

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 February 2018 to January 2019, the trust reported no incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS
In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in maternity which met the reporting criteria set by NHS England from February 2018 to January 2019. This was for maternity/obstetric incidents meeting SI criteria: mother and baby.

(Source: Strategic Executive Information System (STEIS))

Between April 2018 and March 2019, there were a total of 463 incidents reported for the service, of which 457 were classified either as no harm or minor.

The service investigated serious incidents using a root cause analysis approach. We reviewed a completed investigation report that included the lessons learned and a completed action plan. External reviewers were also requested where appropriate, to provide an independent opinion. Parents were invited as part of the investigation process.

At the time of inspection, an incident was being reviewed, by an external organisation, with no further information available.

Staff we spoke with understood the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person.

In line with best practice, births between 22 and 24 weeks, who did not survive were reported to Mothers and Babies Reducing Risks Through Audits and Confidential Enquiries (MBRRACE-UK).

Mortality was discussed monthly at local meetings and at trust mortality review group meetings that were held quarterly. These were attended by midwives and doctors (obstetricians and paediatricians). Cases were presented with any lessons learned or actions included.

Safety thermometer

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

The service displayed patient safety boards that monitored pressure ulcers, falls and staffing to highlight harm free care.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance. Policies we reviewed were current and available for staff to view. Since the last inspection, an enhanced recovery programme had been implemented for elective caesarean sections.

This included guidance from the National Institute for Health and Care Excellence, Royal College of Obstetricians and Gynaecologists and Mothers and Babies Reducing Risks Through Audits and Confidential Enquiries (MBBRACE-UK).

Guidelines, policies and standard operating procedures were discussed at monthly governance meetings. The policies we reviewed were all up-to-date, followed national guidance and latest versions were available on the trust’s intranet for staff to view. The head of midwifery had contributed to National Institute for Health and Care Excellence guidance and was a fellow of the Royal College of Midwives.

The service participated in the perinatal institute’s Growth Assessment Project which monitored the growth of babies in utero, with particular attention to smaller babies.

An audit programme was in place with audits compared to recognised standards and guidelines both internally and nationally.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. Parents could access drinks between meals. An infant feeding strategy had been implemented to support breast feeding.

The service made adjustments for patients’ religious, cultural and other preferences.

An infant feeding strategy (2019) had been implemented, following the recruitment of an infant feeding co-ordinator. Plans included embedding a culture of confidence, support and education both for midwives and women. The service was not currently accredited for UNICEF’s Baby Friendly Initiative, although the target for this was January 2020. Baby Friendly Initiative is a nationally recognised accreditation programme that trains health professionals to support mothers to breastfeed and help parents to build a close and loving relationship with their baby irrespective of feeding method. By December 2018, compliance with infant feeding training was 92% for midwives and 76% for midwifery support workers. Plans included nominating champions in other areas of the hospital as well as offering training to other groups of staff. In addition, women could be directed to the website or social media as well as use of a peer support group.

An action plan was in place to increase the breast-feeding rates that included training and focus groups for staff as well as the implementation of a feeding clinic, review of current policies and discussions with external stakeholders.

There was an infant feeding team who supported women with breast and bottle feeding on the ward. Expressed breast milk was stored in a dedicated milk fridge in a secure room accessed by staff only in the neonatal unit. The strategy included harvesting of colostrum antenataly.
Between December 2017 and November 2018, breast feeding initiation was on average 56% per month compared to the standard of 65%. Skin to skin contact, for the same period, was on average 79% per month.

Formula milk was available at the time of inspection. One cupboard was locked, the other, located in the ward was awaiting a lock, although the cupboard was close to the nurses' station and parents were required to ask staff for the milk.

Women told us that there was a good choice of foods to suit all tastes and preferences. These were served by housekeepers. Trolleys where hot drinks could be made were available for women and their partners in the triage area as well as the wards. Snacks and drinks were available throughout the day and night. Women were encouraged to keep well hydrated, in all areas.

**Pain relief**

Staff recorded pain scores and managed pain well.

Pain scores were recorded as part of the modified early obstetric warning score. We observed midwifery staff checking the comfort levels of patients and saw pain relief being administered as needed.

Alternative forms of pain relief were available including the use of pools and aromatherapy for relaxation.

All women we spoke with told us that staff gave them pain relief medicine when needed.

In the twelve months prior to inspection, trust data showed that there were no reported cases of delayed epidurals being administered.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. Since the last inspection, a maternity dashboard had been implemented and they compared local results with those of other services to learn from them. Since the last inspection, the service had developed a dashboard to record outcomes for women. This included a range of metrics including staff training and appraisal compliance as well as birth numbers, types of births and any incidents. There were no targets included or benchmarking, however we were shown an alternate dashboard that included the Cheshire and Mersey network so the service could benchmark its outcomes.

From the dashboard, post-partum haemorrhage (bleeding after birth) was recorded. Between December 2017 and November 2018, this showed that there had been an average of two haemorrhages of more that 1500mls per month. For the same time period, third and fourth degree tears were recorded and split into spontaneous and instrumental deliveries. For spontaneous deliveries there was an average of four tears; for forceps it was two and ventouse it was one per month.

**National Neonatal Audit Programme**

The table below summarises Warrington Hospital’s performance in the 2018 National Neonatal Audit Programme against measures related to maternity care.
### Metrics (Audit measures)

<table>
<thead>
<tr>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?</strong> (Antenatal steroids reliably reduce the chance of babies developing respiratory distress syndrome and other complications of prematurity)</td>
<td>92.3%</td>
<td>Within expected range</td>
</tr>
<tr>
<td><strong>Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?</strong> (Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later develop cerebral palsy)</td>
<td>66.0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

(Source: National Neonatal Audit Programme)

### National Maternity and Perinatal Audit Programme

The table below summarises Warrington Hospital’s performance in the 2017 National Maternity and Perinatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>100.4%</td>
<td>N/A</td>
<td>✓</td>
</tr>
<tr>
<td>Antenatal measures (before birth, during or relating to pregnancy)</td>
<td>46.7%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date (Babies who are small for their age at birth are at increased risk of problems before, during and after birth)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-partum measures (during labour and birth)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery  
(For babies with a planned (or elective) birth, being born before 39 weeks is associated with an increased risk of breathing problems. This can lead to admission to the neonatal unit. There is also an association with long term health and behaviour problems) | 22.3% | Within expected range | No current standard |
|---|---|---|---|
| Case-mix adjusted overall caesarean section rate for single, term babies  
(The overall caesarean section rate is adjusted to take into account differences which may be related to the profile of women delivering at the hospital) | 25.8% | Within expected range | No current standard |
| Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7  
(The Apgar score is used to summarise the condition of a newborn baby; it is not always a direct consequence of care given to the mother during pregnancy and birth, however a 5-minute Apgar score of less than 7 has been associated with an increased risk of problems for the baby) | 1.3% | Within expected range | No current standard |
| Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear  
(Third or fourth degree tears are a major complication of vaginal birth. Only tears that are recognised are counted therefore a low rate may represent under-recognition as well as possible good practice) | 2.9% | Within expected range | No current standard |
| Case-mix adjusted proportion of women with severe post-partum haemorrhage of greater than or equal to 1500 ml  
(Haemorrhage after birth is a major source of ill health after childbirth. Blood loss may be estimated by visual recognition or by weighing lost blood. High rates may be due to more accurate estimation and low rates due to under recognition) | No data available | N/A | No current standard |
| Post-partum measures (following birth) | | | |
Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit
(Breastfeeding is associated with significant benefits for mothers and babies. Higher values represent better performance)

|                | 59.4% | Bottom 25% of hospitals | No current standard |

Note regarding case ascertainment: Calculated using number of patients reported to the audit as a percentage of the number of patients admitted for the first time to the trust/network and considered eligible within the audit period according to HES. This can be larger than 100% if more patients are reported to the audit than identified in HES (Source: National Maternity and Perinatal Audit Programme)

An audit of use of bilirubinometers by community midwives was undertaken in 2018. Previously assessment of jaundice levels was by paediatrician referral. Of the 203 babies checked by midwives, 8% were referred to paediatricians, whereas previously 100% would have been referred. This meant more babies were supported at home rather than requiring tests in hospital or a clinic.

An audit of gestational diabetes was carried out in 2018. This followed previous audits in 2012 and 2015. Results included that the induction rate had reduced from 66% to 46% with conversion of inductions to elective caesarean section reducing from 22% to 18%. The perineal injury rate had reduced from 50% to 14% and there were no congenital malformations in 2015 results.

An alternative audit for gestational diabetes was carried out in 2018. This reviewed the indicators for screening. Results showed that women were being screened in line with National Institute for Health and Care Excellence guidelines.

An induction of labour audit took place in 2018. Results showed that 82% of inductions were evidence-based. Recommendations included feedback from women as well as further studies to gain more understanding including ways to reduce uterine rupturing.

The service participated in the Growth Assessment Protocol programme which monitored the growth of babies in utero, with particular attention to smaller babies. Following an audit in February 2019, the service has adapted the process in line with regional pathway.

An audit of continuous fetal monitoring using cardiotocography was carried out in March 2019. Results showed that assessments were recorded hourly with stickers used during monitoring. The traces were stored appropriately. An action plan was in place that included reminding staff to check equipment before use.

**Standardised Caesarean section rates and modes of delivery**

From April 2017 to March 2018, the total number of caesarean sections, the standardised caesarean section rates for elective sections and rates for emergency sections were all similar to expected.
In relation to other modes of delivery from April 2017 to March 2018, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
<td>Caesarean rate</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>345</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.9%</td>
<td>364</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.3%</td>
<td>709</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from April 2017 to March 2018, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total caesarean sections¹</td>
<td>709</td>
<td>28.3%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>292</td>
<td>12.4%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>1,599</td>
<td>59.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>2,500</td>
<td>100% (n=596,828)</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics (HES) – provided by CQC Outliers team

Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.
1 Includes elective and emergency caesareans
2 Includes forceps and ventouse (vacuum) deliveries
3 Includes breech and vaginal (non-assisted) deliveries

The service monitored the reasons for caesarean sections on their dashboard including maternal wellbeing, previous caesarean section, multiple pregnancy and poor progression in labour.

Maternity active outlier alerts

As of February 2019, the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2018 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.7. This is up to 10% lower than the average for the comparator group rate of 4.8.

Comparing this provider to other trusts with similar service provision in the 2018 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2016, performance was better than expected...
for stabilised and risk-adjusted extended perinatal mortality rate. There is currently no national aspirational standard for this audit.

(Source: MBRRACE UK)

Between January 2018 and December 2018, there were 12 stillbirths and four neonatal deaths, one of which fulfilled criteria for external review at time of inspection.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance.

**Appraisal rates**

The trust’s target for completion of appraisals was 85% for the financial year. From April 2018 to December 2018, 76.0% of staff within maternity at Warrington Hospital received an appraisal.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Eligible staff</th>
<th>Completed appraisals</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>29</td>
<td>26</td>
<td>89.7%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>10</td>
<td>8</td>
<td>80.0%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>57</td>
<td>40</td>
<td>70.2%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>3</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>76</strong></td>
<td><strong>76.0%</strong></td>
</tr>
</tbody>
</table>

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

At the time of inspection data from the trust showed that:

<table>
<thead>
<tr>
<th></th>
<th>Heads</th>
<th>Number completed</th>
<th>% completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal day unit</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>Community midwives</td>
<td>28</td>
<td>17</td>
<td>61%</td>
</tr>
<tr>
<td>Labour ward</td>
<td>49</td>
<td>44</td>
<td>90%</td>
</tr>
<tr>
<td>Ward 23 (maternity)</td>
<td>31</td>
<td>31</td>
<td>100%</td>
</tr>
<tr>
<td>Specialist midwives</td>
<td>13</td>
<td>12</td>
<td>92%</td>
</tr>
</tbody>
</table>

The trust explained that appraisal for eight community midwives were due for renewal between 14 March 2019 and 27 March 2019; four were completed between 1 April 2019 and 3 April 2019 and the other four were scheduled during April 2019.

The trust also confirmed the overall compliance for each staff group at the time of inspection to show that total compliance was 95%. This included 100% for medical staff, 94% for midwifery staff and 95% for other staff.

Professional midwifery advocates had replaced supervisors of midwives, three midwives had undertaken training however, this was not fully implemented as part of the Cheshire and Mersey network.
**Multidisciplinary working**

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

There was effective internal multidisciplinary team working that included pharmacists, sonographers, maintenance staff and housekeeping as well as doctors, midwives and support workers.

There was an obstetrician who specialised in women’s perinatal mental health. There were joint clinics with psychiatrists and psychologists and women could be referred for further specialist care as needed as well as monthly meetings. Examples were provided where women had attended dedicated women and baby centres.

There was effective external team working. The safeguarding midwife liaised with other professionals when necessary. Records reviewed showed that information was shared appropriately with GPs, and health visitors as well as midwives in the community.

**Seven-day services**

Maternity services were available seven days a week. Medical and anaesthetic cover was provided outside of normal working hours and midwifery staff told us that they felt well supported during these periods.

Sonography was available during weekdays, either in the main ultrasound or with the midwife sonographer. Out of hours scanning was carried out by obstetric doctors if required.

Laboratory, imaging and pharmacy were available if needed following an on-call system at weekends.

**Health promotion**

Records we reviewed showed that health promotion advice was offered during antenatal visits. Risk assessments included discussions about smoking and alcohol in pregnancy. Smoking cessation support was available if required. Referrals were made and women could then choose if they would like to take up the support. Testing for carbon monoxide levels was included in the booking process.

The trust were developing a smart phone application, in collaboration with a national charity who were committed to improving the health and well-being of babies, with priorities including mental health and smoking cessation.

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

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff we spoke with understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support women who lacked the capacity to make decisions about their care.
The trust reported that from April 2018 to December 2018, Mental Capacity Act (MCA) training was completed by 96.0% of staff in maternity at Warrington Hospital compared to the trust target of 85%. Qualified nursing, health visiting and midwifery staff had a completion rate of 89.5%.

Over the same period Deprivation of Liberty Safeguards training was completed by 79.8% of staff in within maternity at Warrington Hospital compared to the trust target of 85%. Qualified nursing, health visiting and midwifery staff had a completion rate of 93.3%.

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

Between December 2017 and November 2018, there were six notifications in maternity services for deprivation of liberty safeguards to CQC.

If patients lacked capacity to make their own decisions, staff made decisions about care and treatment in the best interests of women and involved their representatives and other healthcare professionals appropriately.

We observed staff obtaining verbal consent from women prior to providing care and treatment and written consent was obtained prior to surgery.

Staff we spoke with understood their responsibilities in gaining consent from younger women with regards to Gillick and Fraser competence. Gillick competence is a term originating in England and is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. The ‘Fraser guidelines’ specifically relate only to contraception and sexual health.

There was a trust interpreter and translation service to assist with consent for women whose first language was not English.

Is the service caring?

Compassionate care

Staff cared for women with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

There were numerous thank you cards displayed in all areas of the maternity unit. Women described care from staff as excellent. This included both midwifery and medical staff.

Women were encouraged to provide feedback, about the service with leaflets and boxes available in all areas of the service. Women also chose to contact the service by email where they shared their positive experience as well as baby images.

All staff introduced themselves and communicated well to ensure women fully understood. We observed staff interacting positively with women and those close to them. Staff spoke to women sensitively and appropriately depending on individual need.

Curtains were used appropriately to maintain privacy for families.

We observed a midwife during an ante natal booking appointment. We saw that the midwife interacted well with the woman confirming consent when needed.
We observed a post-natal community visit. There were positive interactions with both parents including involving the father with care of the baby during the visit. The midwife offered advice, support and signposting to the family. The parents were positive about their experience from the antenatal period, including parent education classes and described their midwife as “amazing and inspiring.”

Friends and Family test performance

Friends and family test performance (antenatal), Warrington and Halton Hospitals NHS Foundation Trust

![Graph showing Friends and Family Test performance (antenatal)]

From January 2018 to December 2018, the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was similar to or better than the England average. In the latest period, December 2018, performance for antenatal was 93%, compared to the England average of 95%. Data in November 2018 was not able to be reported on as there were five or fewer responses.

Friends and family test performance (birth), Warrington and Halton Hospitals NHS Foundation Trust

![Graph showing Friends and Family Test performance (birth)]

From January 2018 to December 2018, the trust's maternity Friends and Family Test (birth) performance (% recommended) was similar to or better than the England average. In five of the six months where birth data was available, performance at the trust was 100%. Six months of data were not able to be reported on as there were five or fewer responses.

Friends and family test performance (postnatal ward), Warrington and Halton Hospitals NHS Foundation Trust

![Graph showing Friends and Family Test performance (postnatal ward)]
From January 2018 to December 2018, the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was similar to or better than the England average. Data in December 2018 was not able to be reported on as there were five or fewer responses. In November 2018, performance for postnatal ward was 100%, which was better than the England average of 95%.

**Friends and family test performance (postnatal community), Warrington and Halton Hospitals NHS Foundation Trust**

From January 2018 to December 2018, the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was reported for only four months from February 2018 to April 2018 and in June 2018. The trust’s score in each of these months was 100%. Data in January 2018, May 2018 and from July 2018 was not able to be reported on as there were five or fewer responses.

(Source: NHS England Friends and Family Test)

**CQC Survey of women’s experiences of maternity services 2018**

The trust performed similar to other trusts for all of the 19 questions in the CQC maternity survey 2018.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td>birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.1</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.2</td>
<td>About the same</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.5</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.5</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.1</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>8.9</td>
<td>About the same</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care in hospital after the birth</th>
<th>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</th>
<th>7.5</th>
<th>About the same</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Looking back, was there a delay in being discharged from hospital?</td>
<td>6.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?</td>
<td>7.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?</td>
<td>4.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>8.7</td>
<td>About the same</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2018)
The trust told us that it had improved in 2018 compared to 2017 and had higher scores to other providers on 25 questions compared to five in 2017.

**Emotional support**

Staff provided emotional support to parents to minimise their distress including at times of bereavement with an award winning service that offered memory boxes for losses or for perinatal mental health issues.

We observed staff providing reassurance and comfort to women. Staff provided support as required.

There were dedicated outpatient clinics for women with perinatal mental health concerns. These included counselling where needed and joint clinic support from a psychologist. A mental health liaison nurse supported these clinics and provided women with a range of information such as signposting to local peer support groups. Women could also be referred to local mother and baby units if deemed appropriate.

Since the last inspection, a bereavement suite had been established. The specialist bereavement midwife provided support to families. Generally, visits were offered up to 12 months, including attendance at funerals, following a bereavement, although following contact with the trust, a woman was visited 10 years after a loss. Memory boxes were personalised and could include hand and footprints. A SIM card of photographs was given. The unit was supported by bereavement charities. There was donated knitwear, in a range of sizes, and soft toys. Cool cots and cuddle cots were available so that parents could spend time with their baby either in the suite or at home. There was also a sensory garden where families could visit outside of the suite. Bereavement at all stages was supported including early losses known as tiny stars. In 2018, there were 15 families who chose to take home sealed caskets for their early loss. For losses up to 24 weeks gestation, birth certificates were given out. Families were presented with wooden initials on the anniversary of the loss.

There were annual remembrance services held around Christmas time for bereaved families as well as a Mother’s Day pampering event for tiny stars families. There was a book of remembrance located in the chapel as well as a book in the suite. The service received numerous thank you cards. One example was handmade and included a footprint of the baby as well as picture that was the name of the baby. The wallpaper, in the suite was the same picture; the midwife sent a photo to the family to show the baby will be remembered.

For women who received a diagnosis of fetal anomaly, in the antenatal period, the midwife contacted the families to offer support and show them the suite. Five bereavement champions had been identified to attend training and support the bereavement midwife. Bereavement training was included in mandatory training for all staff.

**Understanding and involvement of patients and those close to them**

Staff involved women and those close to them in decisions about their care and treatment. Birth partners were able to be resident with the woman.

We observed staff interacting positively with women and those close to them. Staff spoke to families sensitively and appropriately, dependent on individual need. Staff respected women’s
choices and delivered their care with an individualised person–centred approach. Women’s care records were individualised to take into account their personal wishes. Women were encouraged to ask questions and were given time to ensure they understood what was being said to them.

Women and those close to them told us that they received information in a manner that they understood. Birth partners were encouraged to attend with women and be resident if they chose to.
Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people. Women could choose to have care at the trust as well as other local providers.

Bed Occupancy

From April 2017 to September 2018, the bed occupancy levels for maternity were lower than the England average, with the exception of July to September 2017 where levels were similar.

In the latest quarter, July 2018 to September 2018, occupancy levels were at the lowest over the two-year period with 48.3% compared to the England average of 59.6%.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Women could self-refer to the service either by the trust website, phone or a social media site. In February 2019 the trust introduced the new electronic booking and referral process which enabled patients to refer to the service at any time. They received a welcome call within 24 hours, followed by a pack with useful information. A call to schedule an appointment with a midwife was then made within two weeks.

The maternity service had a dedicated entrance from outside, away from the main hospital entrance. There was clear signage to the department as well as throughout the hospital.

The service made arrangements for women who chose to attend antenatal clinics and have post-natal care at this trust and planned for delivery in a different trust or have deliver at this trust and have appointments elsewhere.
Women could be seen antenatally in GP surgeries or children’s centres close to their homes rather than visiting the hospital each time.

There were joint clinics for women with additional medical need including diabetes or mental health. Plans for a post-dates clinic were in place to start soon.

There were facilities available for parents on the ward and in the triage area to make hot drinks for drinks. Water was available in all areas of the service.

There were a range of leaflets available in antenatal areas and on the wards. Parent education classes were available out of hours to accommodate working parents.

The bereavement suite was a spacious bright area located away from other delivery rooms. There were two rooms that had been recently decorated in calming colours, one with a hospital bed and the other with a double bed.

There was a room, in the maternity ward, for the newborn and infant physical examination and future plans included setting up a dedicated clinic.

Meeting people’s individual needs

The service took account of women’s individual needs. It was accessible for women with reduced mobility and interpreters were available. Women with mental health or learning disabilities were cared for appropriately.

Partners of women were able to remain with women throughout their stay. Hot and cold drinks were freely available to partners; meals needed to be sourced outside of the maternity unit. Partners could sleep in chairs next to the bed. There were plans to purchase more recliner-type chairs for partners resident for several days as well as a shower facility for the partners on the ward.

All areas of the maternity service were accessible for women who required to be transported in a wheelchair including disabled toilet facilities.

A trust-wide translation service was available for women whose first language was not English. The labour ward suite produced laminated information sheets for women for certain procedures and could access others if needed.

The service had access to information in 27 languages from a pregnancy information website. Trust information was available in 'easy read'. Any woman identified as having a learning disability would be identified in the antenatal period when an individual package of care could be put in place.

Staff were sensitive to patient need. We observed that a woman who transferred from the labour ward to the maternity ward, was accommodated in a side room following a request.

There was an area designated as a bereavement suite. It had won the award in 2018 for being the best hospital bereavement service. It included en-suite facilities for parents as well as kitchen areas.

There was no hearing loop on the ward, although if needed a sign language expert could be sourced if needed. There was no dedicated hearing test room for babies. These were carried out in the bays. To help reduce background noise, temporary signs were used to indicate tests were in progress. The hearing technicians had reported improvements in the quality of the tests since the introduction of the signs.
The service employed specialist midwives that included infant feeding, drug and alcohol, smoking cessation, bereavement, risk, safeguarding, research and mental health. A midwifery led acupuncture service was available weekly if required.

The consultant midwife held a clinic for women with an individual need such as tokophobia (fear of birth), a caesarean for non clinical reasons, a previous caesarean or women who choose care that falls outside of routine guidance. This could include one to one birth preparation workshops, small group workshops or support via telephone and text.

Special circumstances forms were completed, in the antenatal period for women identified with a particular need such as a learning disability. Staff we spoke with told us that they would be made aware prior to birth and would be highlighted on the trust’s electronic system. The trust used a learning disability passport to support women, although there was no information seen in an ‘easy read’ format.

The trust feedback forms included a section that asked if women had any long-standing conditions including hearing or visual impairment, a learning disability, a mental health condition or a long-standing physical condition or illness.

**Access and flow**

Women could access the service when they needed it. Since the last inspection a triage service had been implemented as well as an antenatal day unit. Waiting areas in the antenatal clinic had improved to try and differentiate between obstetric and gynaecology waiting.

There had been two episodes when the unit needed to close between April 2018 and February 2019.

From December 2017 to November 2018, the maternity dashboard showed that on average, 87% of women were booked by 13 weeks gestation.

There was a team of midwives that provided a maternity triage service between 8am and 6pm Monday to Sunday. Out of hours, women could contact the labour ward for support.

Each woman had a named midwife, providing individualised continuity of care from the community team in the antenatal and postnatal periods. Midwives worked in teams, supporting each other and women in their care.

Prior to discharge, babies underwent the newborn and infant physical examination. During weekdays, this was carried out by a paediatrician. From the last inspection, there had been delays in discharge due to waiting for the examination. Twenty-two midwives, in the service were now trained to carry out this examination; therefore, preventing a delay.

From January 2018 to December 2018 there were 2,558 deliveries at the trust. Of these, 2,269 were in the labour ward, 259 were in the midwifery-led unit and 28 were homebirths.

In the event of a busy period community midwives could support the midwifery-led unit while other midwives, with skills for more high-risk women, could support the labour ward.

Between February 2018 and January 2019, the trust told us that there was an average monthly readmission rate of 5% within 42 days of birth.
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Summary of complaints

From December 2017 to December 2018, there were 30 complaints about maternity at Warrington Hospital. The trust took an average of 31 working days to investigate and close complaints. The trust’s complaints policy, which states complaints should be completed within 60 working days for high graded complaints and 30 working days for moderate and low graded complaints. The vast majority of complaints are moderate and low grade.

The most common theme was patient care with 22 complaints (64.7%), followed by values and behaviours (staff) with six (17.6%).

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

Number of compliments made to the trust

From January 2018 to December 2018, there were three compliments within maternity at Warrington Hospital.

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

We reviewed a complaint that was upheld. Although the completion time was delayed, the complainant had been contacted prior to the final response. The letter was personalised, indicated sympathy and addressed the issues highlighted.

Staff told us that lessons learned were shared by senior staff either at team meetings or in trust-wide newsletters.

There were leaflets displayed in all areas to guide patients on how to provide feedback about the service.
Is the service well-led?

Leadership

Maternity services had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

There were clearly defined and visible leadership roles across the maternity service. Maternity services were part of the Women’s and Children’s Division at the trust.

The senior management team included the clinical director, the clinical business unit manager and the head of midwifery. There were two maternity matrons who were supported by ward managers, shift co-ordinators and a team of midwives and health care assistants.

Medical and midwifery staff understood reporting structures and told us they were well supported by their managers.

Senior managers told us that they felt supported by the trust executives and they were very approachable.

There was maternity lead representation on the trust board championing the service.

Vision and strategy

The trust had a vision and strategy for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. A new midwifery-led birthing unit was planned, that included the re-location of the induction of labour area by the end of the year.

The maternity services strategy 2018–2021 included that “Our vision is to be a service that is recognised for its safety, quality care and kindness. It places Women, Children and Families first, today, tomorrow and always.” The strategy included offering safe personalised continuity of care using a multidisciplinary approach. This included care in the postnatal period and perinatal mental health as well as following the regional Cheshire and Mersey Network.

The developed services in line with the Cheshire and Mersey Strategy 2017–2021 “Improving Quality, Safety and Effectiveness in Maternity Care”. This strategy was for a group of trusts that incorporated the whole region in line with Better Births guidance. The vision for this group of trusts was: “To commission and provide safe, high quality, sustainable maternity services for all with women at the heart of them and using better information and care throughout pregnancy will improve outcomes and the health and wellbeing of mothers and babies for the rest of their lives.”

The service and regional strategies were also supported in the trust’s clinical strategy with maternity services “to look to join up care between in and out of hospital settings where appropriate ensuring it is safe, responsive, individualised and evidence-based at all times.”

There were approved plans to re-locate the induction of labour beds into individual rooms in the labour ward and the midwifery led unit was moving to the ground floor in a new birthing centre, along with all community services later in the year.

There was also plans for ‘pop up’ birthing centres in the community in the months following inspection.
Culture

Managers across the trust promoted a positive culture that supported and valued staff.

There was an open and transparent culture that encouraged reporting of incidents in order to learn from them and improve quality for people in the local community.

There was a positive attitude and culture where staff valued each other. Staff reported good team working. Community midwives reported feeling part of the whole maternity team particularly with the new plans upcoming.

All staff were passionate about the service they provided and felt supported by their managers.

Staff we spoke with had been employed by the trust for varying lengths of time, but all staff demonstrated a strong commitment to the hospital.

There was a lone worker policy that included the use of electronic devices for community staff as well as checking in and out processes.

The delivery suite, neonatal unit and labour ward had all been awarded team of the month since the last inspection and one of the community midwives had been awarded employee of the month.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care.

A risk midwife had responsibilities for monitoring governance arrangements including facilitating or reporting incident investigations as well as maintaining the risk register for the service.

The service collected data to monitor and improve performance. Maternity dashboards captured compliance with a number of indicators.

The midwifery and obstetric improvement committee met monthly. Members included obstetricians and midwifery managers. There were discussions about maternity services such as triage, staffing, competencies, equipment, safeguarding and induction of labour.

Governance meetings for the division were held monthly. These were attended by the clinical business unit managers (women’s and children’s). Agenda items discussed included the risk register, dashboards, clinical effectiveness, alerts, incidents, policies and guidelines and infection control.

There was also a women’s health senior staff meeting that met monthly attended by the leads in the clinical business unit where strategy and plans were discussed.

Monthly team meetings took place as well as quarterly perinatal meetings. These could be attended by all grades of medical and midwifery staff with agenda items such as matters arising, fetal anomalies and unanticipated admissions.

The trust issued a weekly safety brief to share learning across the trust. Actions from meetings were identified with delegated responsibilities.
Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Since the last inspection, the risk midwife reviewed risks monthly.

A clinical governance process was in place within the maternity service that allowed risks to be escalated to divisional and trust board level.

The service maintained a risk register as part of the Women and Children’s Division. The risk midwife monitored the register; it was reviewed monthly. Following the last inspection, items included actions needed to improve the service. Risks were clearly identified with control measures in place to help reduce the risk.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Paper records for patients were securely stored in lockable trolleys or offices.

The service had developed a dashboard to record outcomes for women. This included a range of metrics including staff training and appraisal compliance as well as birth numbers, types of births and any incidents.

Engagement

The trust engaged well with women, staff, the public and local organisations to plan and manage appropriate services and collaborated with organisations such as maternity voices effectively.

The maternity voices forum was re-launched in May 2018 with bi-monthly meeting for families and staff. From this, the 15 steps toolkit programme identified some changes that could improve the experience of women in hospital. These included the opening of shutters that were generally closed, in the antenatal clinic, a magnetic board with parents’ feedback displayed and ‘tell us’ tags on the maternity ward. These tags were for women to note down anything to ask staff about. On the maternity ward, there was a tree with tags attached. This could be used by staff and parents to attach a comment to pass on. It was a seasonal tree and decorated according to seasons and celebrations.

A pilot scheme for a social media site for women with midwives’ support had taken place with plans to implement fully in the future. The trust were developing a smart phone application, in collaboration with a national charity who were committed to improving the health and well-being of babies.

The service used social media to share information and promote events.

Staff took part in charity activities including raffles, to raise extra funds for the unit.

A recent open day was well supported by staff with 150 women and families attending. Staff provided voluntary support, on a Saturday to families offering support for signposting, smoking cessation, hypnobirthing and signposting to services. There was also tours of the unit, knitting sessions and demonstrations of baby slings by obstetricians.
A ‘glimpse of brilliance’ board, on the ward, displayed staff photos to highlight positive actions by staff and also the head of midwifery handed out special postcards to staff when appropriate. The service promoted ‘kindness’ to staff as part of the Royal College of Midwives caring for you programme. Staff had introduced being ‘mugged’. This meant that a member of staff bought a mug and filled it with treats before leaving it for the staff member nominated. In turn the person ‘mugged’ then ‘mugged’ someone else in turn. There was a closed social media site for midwives.

Monthly team meetings took place as well as quarterly perinatal meetings. These could be attended by all grades of medical and midwifery staff with agenda items such as matters arising, fetal anomalies and unanticipated admissions.

The trust issued a weekly safety brief to share learning across the trust.

The service had achieved silver in the trust’s ward accreditation scheme in December 2018. The assessor was positive about the initiative ten at ten where staff are encouraged to take a break for tea and toast.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. Plans included reorganisation of the service in order to offer more choices

The service was involved in a number of national research and quality improvement programmes including medicines in pregnancy and Group B streptococcus infection. Studies have been published in medical journals and have led to changes in national guidelines. The Head of Midwifery had contributed to national guidance and literature and had been awarded an MBE for contribution to midwifery.

In June 2017 the service held a ‘whose shoes event’ with staff, women and other stakeholders experiencing life from someone else’s perspective. Following the event improvements were made to the maternity services including partners being able to stay overnight, refreshments for families, tell me tags to share information to staff and changes to terminology.

The service employed a research midwife who supported staff in any projects. The service participated in national research programmes such as pre-eclampsia.

For women identified antenatally with a blood type including rhesus negative, they could have their blood tested to see if the babies’ blood was going to be rhesus positive or negative. This meant that the woman would not always need an injection of anti-D depending on the results.

There were plans in place, in the upcoming months, to reorganise services provided. These included a midwifery led unit positioned with antenatal services and greater involvement by community midwives. This meant the induction of labour bay would be moved to the labour ward.

There were also plans to create two pop-up birth centres which offered a further option to low-risk pregnant women.
Surgical services at the Halton site which included the Cheshire and Merseyside treatment centre are managed by the digestive diseases, musculoskeletal and specialist surgery clinical business units, these were responsible for the delivery of surgical services at the Warrington site also.

These services undertaken include: General surgery which comprised of upper gastro-intestinal, colorectal, thyroid, breast services, urology, ear nose and throat, ophthalmology, trauma and orthopaedics, oral surgery and orthodontics.

The Halton site has a 27 bedded ward (Ward B4) which accommodated both inpatients and day-case patients and the Cheshire and Merseyside treatment centre, which is used for elective trauma and orthopaedics, has a 30 bedded ward which accommodated both inpatient beds and day-case patients.

The Halton site comprises of four elective theatres, one clinical treatment room and two recovery areas, whilst the Cheshire and Merseyside treatment centre has four elective theatres and one recovery area.

The service had 15,096 surgical admissions from February 2018 and January 2019. 12,748 were elective day case procedures, 2,315 were elective inpatient procedures and 33 were non elective. Of these 90 were undertaken on patient aged 16 or 17 years.

The Care Quality Commission (CQC) carried out a comprehensive inspection between 2 and 12 April 2019. This inspection looked at the surgical services provided at the Halton hospital site and included the Cheshire and Merseyside treatment centre.

During this inspection we visited the operating theatres, surgical inpatient and day case wards and the pre-operative assessment clinic at Halton hospital and the operating theatres, surgical inpatient and day case wards and the pre-operative assessment clinic at Cheshire and Merseyside treatment centre.

We spoke to seven patients, 25 members of staff including senior managers, nurses, student nurses, health care assistants, consultants, middle grade doctors, pharmacists, allied health professionals, pharmacists, domestics and ward clerks.

We observed care and treatment and looked at 11 patient care records. We reviewed comments from staff focus groups and we looked at the service performance data.
Is the service safe?

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

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

Mandatory training

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

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

Trust level

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th></th>
<th></th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls awareness &amp; post falls pathway - No renewal</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>91</td>
<td>91</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>98</td>
<td>99</td>
<td>99.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>79</td>
<td>81</td>
<td>97.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>92</td>
<td>96</td>
<td>95.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS conflict resolution (England) - 3 years</td>
<td>81</td>
<td>87</td>
<td>93.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>89</td>
<td>96</td>
<td>92.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Counter fraud - no renewal</td>
<td>75</td>
<td>81</td>
<td>92.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management awareness - no renewal</td>
<td>35</td>
<td>38</td>
<td>92.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>68</td>
<td>75</td>
<td>90.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 1 - 3 years</td>
<td>15</td>
<td>17</td>
<td>88.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control - level 2 - 1 year</td>
<td>78</td>
<td>89</td>
<td>87.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - 3 years</td>
<td>55</td>
<td>63</td>
<td>87.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>43</td>
<td>57</td>
<td>75.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention and control - level 1 - 3 years</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resus level 2</td>
<td>85</td>
<td>118</td>
<td>72.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
In surgery the 85% target was met for 13 of the 16 mandatory training modules for which qualified nursing staff were eligible.

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

| Training module name | April 2018 to December 2018 | | | | |
|----------------------|----------------------------|----------------|----------------|----------------|
|                      | Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No) |
| Infection prevention and control - level 1 - 3 years | 7 | 7 | 100% | 85% | Yes |
| Dementia awareness - No renewal | 50 | 51 | 98.0% | 85% | Yes |
| Equality, diversity and human rights - 3 years | 42 | 43 | 97.7% | 85% | Yes |
| Health, safety and welfare - 3 years | 42 | 43 | 97.7% | 85% | Yes |
| Resuscitation - level 1 - No specified renewal | 38 | 39 | 97.4% | 85% | Yes |
| Falls awareness & post falls pathway - 3 years | 22 | 23 | 95.7% | 85% | Yes |
| Moving and handling - level 2 - 3 years | 15 | 16 | 93.8% | 85% | Yes |
| Counter fraud - No renewal | 47 | 51 | 92.2% | 85% | Yes |
| NHS conflict resolution (England) - 3 years | 31 | 34 | 91.2% | 85% | Yes |
| Fire safety - 1 year | 39 | 43 | 90.7% | 85% | Yes |
| Information governance - 1 year | 39 | 43 | 90.7% | 85% | Yes |
| Falls awareness & post falls pathway - No renewal | 17 | 19 | 89.5% | 85% | Yes |
| Infection prevention and control - level 2 - 1 year | 30 | 35 | 85.7% | 85% | Yes |
| Moving and handling - level 1 - 3 years | 22 | 26 | 84.6% | 85% | No |
| Resus level 2 | 32 | 38 | 84.2% | 85% | No |
| Medicines management awareness - No renewal | 31 | 39 | 79.5% | 85% | No |

In surgery the 85% target was met for 13 of the 16 mandatory training modules for which medical staff were eligible.

The trust report that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. This means that the trust is unable to break down the mandatory training data for medical staff for Warrington and Halton Hospitals.

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 for medical staff in the surgery department at Warrington and Halton Hospitals is shown below:

<p>| Training module name | April 2018 to December 2018 | | | | |
|----------------------|----------------------------|----------------|----------------|----------------|
|                      | Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No) |
| Counter fraud - No renewal | 35 | 35 | 100% | 85% | Yes |
| Dementia awareness - No renewal | 35 | 35 | 100% | 85% | Yes |</p>
<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Counter Fraud - No Renewal</td>
<td>7</td>
</tr>
<tr>
<td>Dementia Awareness - No Renewal</td>
<td>7</td>
</tr>
<tr>
<td>Falls Awareness &amp; Post Falls Pathway - 3 Years</td>
<td>6</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>21</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>20</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>20</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>18</td>
</tr>
<tr>
<td>Information Safety - 1 Year</td>
<td>18</td>
</tr>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>17</td>
</tr>
<tr>
<td>Medicines Management Awareness - No Renewal</td>
<td>3</td>
</tr>
<tr>
<td>Moving and Handling - Level 2 - 3 Years</td>
<td>15</td>
</tr>
<tr>
<td>Resus Level 2</td>
<td>17</td>
</tr>
</tbody>
</table>

Halton Hospital surgery department

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 for qualified nursing staff in the surgery department at Halton Hospital is shown below:
At Halton Hospital surgery department, the 85% target was met for nine of the 12 mandatory training modules for which qualified nursing staff were eligible.

The trust report that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. This means that the trust is unable to break down the mandatory training data for medical staff for Warrington and Halton Hospitals.

**Cheshire and Merseyside Treatment Centre surgery department**

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 for qualified nursing staff in the surgery department at Cheshire and Merseyside Treatment Centre is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</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>Counter fraud - No renewal</td>
<td>25</td>
<td>25</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>25</td>
<td>25</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Medicines management awareness - No renewal</td>
<td>24</td>
<td>25</td>
<td>96.0%</td>
<td>85%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - 3 years</td>
<td>21</td>
<td>25</td>
<td>84.0%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Resus level 2</td>
<td>21</td>
<td>29</td>
<td>72.4%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Infection prevention and control - level 2 - 1 year</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>NHS conflict resolution (England) - 3 years</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

At Cheshire and Merseyside Treatment Centre surgery department, the 85% target was met for six of the 13 mandatory training modules for which qualified nursing staff were eligible. For eight of the modules only two members of staff were eligible. Performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 for medical staff in the surgery department at Cheshire and Merseyside Treatment Centre is shown below:
<table>
<thead>
<tr>
<th>Category</th>
<th>Duration</th>
<th>Achieved</th>
<th>Passed</th>
<th>Renewal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>20</td>
<td>20</td>
<td>100%</td>
<td>85%</td>
</tr>
<tr>
<td>Infection prevention and control - level 1 - 3 years</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>85%</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>19</td>
<td>20</td>
<td>95.0%</td>
<td>85%</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>19</td>
<td>20</td>
<td>95.0%</td>
<td>85%</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>85%</td>
</tr>
<tr>
<td>Resuscitation - level 1 - no specified renewal</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>85%</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - No renewal</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>85%</td>
</tr>
<tr>
<td>Infection prevention and control - level 2 - 1 year</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>85%</td>
</tr>
<tr>
<td>NHS conflict resolution (England) - 3 years</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>85%</td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>18</td>
<td>20</td>
<td>90.0%</td>
<td>85%</td>
</tr>
<tr>
<td>Moving and handling - level 1 - 3 years</td>
<td>16</td>
<td>19</td>
<td>84.2%</td>
<td>85%</td>
</tr>
<tr>
<td>Resus level 2</td>
<td>13</td>
<td>16</td>
<td>81.3%</td>
<td>85%</td>
</tr>
<tr>
<td>Medicines management awareness - No renewal</td>
<td>12</td>
<td>15</td>
<td>80.0%</td>
<td>85%</td>
</tr>
<tr>
<td>Counter fraud - No renewal</td>
<td>12</td>
<td>16</td>
<td>75.0%</td>
<td>85%</td>
</tr>
</tbody>
</table>

At Cheshire and Merseyside Treatment Centre surgery department, the 85% target was met for 10 of the 14 mandatory training modules for which medical staff were eligible.

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

The service had a mandatory training policy. This was based on a training needs analysis which determined which training staff had to undertake based on their roles and responsibilities. They were required to undertake a range of general and role specific mandatory training modules in line with the policy and the mandatory training schedule. This also set out the frequency that each module was to be repeated. The majority of these were online training.

Subjects deemed mandatory included resuscitation, moving and handling, medicines management, equality and diversity and manual handling.

During our inspection we found that team managers monitored their team’s compliance with mandatory training and that compliance was good. Managers told us plans were in place to ensure compliance rates were reviewed regularly and staff were encouraged to complete them. We saw that in most cases where a member of staff showed they were not compliant, they were booked on a course in the near future. Some gaps were due to long term sickness.

**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 85% for completion of safeguarding training.

Trust level

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>45</td>
<td>46</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>81</td>
<td>83</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>112</td>
<td>115</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>69</td>
<td>75</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>61</td>
<td>71</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>61</td>
<td>73</td>
</tr>
</tbody>
</table>

In surgery the 85% target was met for five of the six safeguarding training modules for which qualified nursing staff were eligible.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Safeguarding children - level 3 - 3 years</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>34</td>
<td>37</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>35</td>
<td>39</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>32</td>
<td>37</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>28</td>
<td>33</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>23</td>
<td>33</td>
</tr>
</tbody>
</table>

In surgery the 85% target was met for five of the seven safeguarding training modules for which medical staff were eligible.
The trust report that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. This means that the trust is unable to break down the safeguarding training data for medical staff for Warrington and Halton Hospitals.

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 for medical staff in the surgery department at Warrington and Halton Hospitals is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding children - level 3 - 3 years</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>20</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>21</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>19</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>15</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>13</td>
</tr>
</tbody>
</table>

At Warrington Hospital surgery department, the 85% target was met for five of the seven safeguarding training modules for which medical staff were eligible.

**Halton Hospital surgery department**

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 for qualified nursing staff in the surgery department at Halton Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>21</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>20</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>23</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>6</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>5</td>
</tr>
</tbody>
</table>

At Halton Hospital surgery department, the 85% target was met for five of the six safeguarding training modules for which qualified nursing staff were eligible.
The trust report that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. This means that the trust is unable to break down the safeguarding training data for medical staff for Warrington and Halton Hospitals.

**Cheshire and Merseyside Treatment Centre surgery department**

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 for qualified nursing staff in the surgery department at Cheshire and Merseyside Treatment Centre is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>2</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>27</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>25</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>26</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>22</td>
</tr>
</tbody>
</table>

At Cheshire and Merseyside Treatment Centre surgery department, the 85% target was met for five of the six safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 for medical staff in the surgery department at Cheshire and Merseyside Treatment Centre is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>14</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>14</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>14</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>13</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>13</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>10</td>
</tr>
</tbody>
</table>

At Cheshire and Merseyside Treatment Centre surgery department, the 85% target was met for four of the six safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
The service had a trust wide safeguarding team which included the chief nurse who was the executive lead for safeguarding at the trust and a trust wide head of safeguarding. There were also designated lead doctors and safeguarding lead nurses for both vulnerable adults and children and young persons.

The safeguarding team was available during core hours for staff to contact should they have any safeguarding queries or concerns. Outside of these hours we were advised staff could contact on call managers who could then provide advice if required. Safeguarding link staff attended forums, where information was cascaded in both directions, this information fed into the main safeguarding committee along with briefings by the surgical clinical business units which highlighted issues, good practice and learning.

There was a safeguarding policy in place which accessible to staff. Staff we spoke with could explain what they would do if they had a concern about a patient or their family member and they understood the correct process to follow.

Clinical and nursing staff in the service were currently trained to level 2 in the safeguarding of vulnerable adults. Recent guidance in the intercollegiate document entitled ‘Adult Safeguarding: Roles and Competencies for Health Care Staff,’ says “all registered health and social care staff working with adults who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns”, should receive level three training. This guidance is new and the trust were at the time of inspection deciding on levels of training in the light of this guidance.

The service had deemed that clinical staff on the wards, in the operating theatres and in the theatre’s recovery areas were required to be trained to level two in the safeguarding of children and young people. However, as the service treated young people aged 16 and 17, intercollegiate guidance stated they should be trained to level three. Managers in the service stated they were currently considering the levels of training required by such staff in response to the guidance.

Staff did however have access to individuals who were trained to level 3 in the safeguarding of children and young people, such as team managers. Furthermore, each area had a safeguarding 'champion' or link nurse who could support staff with potential concerns. There was also a children’s ward on the Warrington hospital site which was accessible by telephone for advice at any time of the day or weekends. Following our inspection, we saw that the trust had started to implement level three training for such staff and we saw that training sessions with dates had been arranged. Information regarding the sessions was shared on the trust’s morning safety bulletin.

The service had a system to highlight when there was a planned admission for a young person aged 16 or 17. The service had a process whereby the young person had a choice if they were treated on the children’s ward at the Warrington site or if they wanted their treatment through adult services at Halton. If the young person was to be treated at Halton then staff would inform the trust safeguarding team who would ensure co-ordinators and relevant staff were aware they were present.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

During our inspection we observed that wards appeared visibly clean and tidy and free from clutter. We saw evidence that cleaning regimes were in place and that these were audited.
regularly as part of the quality metrics package. A dashboard was available to managers to monitor performance in this and other audits.

Where audit outcomes fell short of 100% compliance, they were highlighted to managers to ensure the areas of non-compliance were revisited and cleaned.

Cleaning staff were part of the ward and area team and employed by the trust. Managers felt this worked very well as cleaning staff took ownership of their own areas. We saw staff cleaning equipment and devices following use by a patient. We saw that stickers were placed on such items to identify they had been cleaned.

An infection prevention and control policy was in place and we found staff were aware of this policy. There was an infection prevention and control team within the trust and infection prevention and control link nurses in place in each area. A range of infection prevention and control audits were conducted monthly these covered areas such as peripheral line insertion and care and hand hygiene. The results were sent to ward managers to produce action plans. Where appropriate, additional training was undertaken and random spot checks conducted as follow up actions.

Infection prevention and control was classed as a component of mandatory training for clinical staff. The compliance rate for staff at Halton and Cheshire and Merseyside treatment centre was 84%, the trust target was 85%.

During our inspection we saw that staff were compliant with best practice in relation to uniform standards and ‘arms bare below elbows’ guidance, we also saw that they used appropriate personal protective equipment and washed their hands in between contact with patients.

We saw good access to hand washing stations, sinks and hand gels on the wards, in theatres and also at the point of care. However, we found that ten hand sanitising gels with the Cheshire and Merseyside treatment centre were out of date. This was raised with staff who replaced the gels immediately.

We observed good compliance with handwashing from staff and members of the public. Hand washing plays an important part in helping to prevent the spread of infection.

We saw that where patients were subject to isolation precautions due to a potential infection that this was highlighted appropriately and that signage was present to advise those entering the room of the precautions to take and doors were closed.

All patients were screened for methicillin-resistant Staphylococcus aureus as part of the pre-operative assessment processes.

The decontamination of reusable medical devices was completed in line with national guidance. Sterilisation, where required, was undertaken on through a service level agreement with an external provider.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

We found that the clinical areas were well maintained and provided a suitable environment to care for patients. Waste and clinical specimens were handled and disposed of in a way that kept people safe. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.
The service used single-use, sterile instruments as appropriate. The single use instruments we saw were within the manufacturers’ expiry dates. The service had arrangements for the sterilisation of reusable instruments which were contracted out and monitored through a service level agreement with an external provider. We were advised that the relationship with the external provider was good and there were arrangements in place for a quick turn-around for items that were needed urgently.

Emergency and resuscitation equipment was accessible in the ward and theatre areas. Records were kept which showed these were checked in line with hospital policy. The emergency trolleys were equipped with a defibrillator, oxygen, portable suction and a selection of emergency items. Emergency medicines and fluids were kept in tamper evident cases on the emergency trolleys. The emergency trolley on the pre-operative assessment unit did not have a defibrillator or oxygen, this was in line with trust policy as it was deemed to be a low risk and had ‘level 2’ items only.

At our previous inspection we found some out of date consumable and perishable items in use on emergency trolleys, dressings trolleys and in store rooms. During this inspection we found a similar situation.

We checked sample of items and found several out of date items;

- A nasopharyngeal airway on the emergency trolley on the Cheshire and Merseyside treatment centre inpatient ward,

- 30 plaster of Paris packets on the Cheshire and Merseyside treatment centre pre-operative assessment clinic.

- Nine urine sample bottles, a tub of urine dip sticks, three sterile sutures and two sterile absorbent dressing pads were out of date on the Cheshire and Merseyside treatment centre admissions area.

Staff had access to the equipment they needed to care for patients and on the whole maintained and used equipment in a way that helped keep people safe. Standard operating procedures were in place to help staff use and check equipment. However, we found two oxygen cylinders on the admissions area at Cheshire and Merseyside treatment centre were not secured to the wall.

Equipment and machines were serviced and maintained by the trust medical engineering staff. They held a database of annual servicing dates and arranged for these to be completed. We were advised that a process was in place whereby equipment due for servicing was monitored. During our inspection we checked a sample of equipment such as blood pressure machines, hoists and bladder scanners and we found on the whole they were serviced appropriately and in date.

However, we found six items of blood pressure monitoring equipment and observations machines in the Cheshire and Merseyside treatment centre and an electrocardiogram machine in the Cheshire and Merseyside treatment centre pre-operative assessment unit were overdue for service. This was raised with staff at the time and they were taken out of service. We also found that 12 trolleys in the admissions area at the Cheshire and Merseyside treatment centre had not been serviced. We were advised that as these were not being used to actively move patients staff believed they did not need to be serviced. As patients were still using these trolleys and they might potentially be adjusted, they still required servicing to ensure they remained fit for purpose.

Following the inspection, we were advised that all 12 trolleys had been serviced the following working day.

We were advised that there was a process in place to request repairs and replacements of equipment. This was managed by the trust medical engineering staff.
During our inspection, we found items subject to the 'control of substances hazardous to health' were stored appropriately.

We observed a hoist blocking a fire escape between wards B4 and B3, this was highlighted to the ward manager and this was moved straight away. We also noted that television trolleys were in front of fire escape in some bays on ward B4, however, these were on trolleys with wheels and were easily moveable if access to the fire escape was needed. We were told that this situation had been risk assessed by the service and deemed to be acceptable practice.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. The service used and checked the use of surgical safety checklists. This was an improvement from the last inspection.

During our previous inspection, the service was found to have some lapses in processes around the World Health Organisation checklist and the ‘five steps to safer surgery’. The five steps to safer surgery are; the pre-operative brief, the sign in, the time out, the sign out and the post-operative debrief. These processes have been devised and are used internationally and have been shown to reduce the chances of safety incidents occurring during surgical procedures.

During this inspection we found that those processes had improved significantly. We found that teams paid good attention to the five stages of the process, however we found that the surgeon did not always participate in the sign in phase. We learned that this was common practice currently but that a new process was soon to be introduced which would require the surgeon to be present at the sign in. Guidance suggests that ‘ideally’ the surgeon should be present at sign in to check that the surgical site has been marked and is aware of the safety processes discussed during this phase.

During our inspection we reviewed the processes and documentation around the pre-operative briefing. This is the stage where individual theatre team discuss the theatre list and each individual patient on the list to determine any risks or requirements for each patient. During our inspection we found that the documentation currently in use did not adequately ensure that all pre-operative issues could be documented against individual patients, this had led to a ‘work around’ whereby notes were being made on theatre lists themselves. We found some of the notes on theatre checklists were difficult to decipher and these were shredded at the end of the day, therefore they did not provide an audit trail of the process, nor provide a clear and legible account of potential safety issues for each patient. This potential area for improvement had been recognised by the service and they had undertaken a lot of preparatory work, research and planning to determine a more effective process. Representative from a theatres quality and safety working group had visited other NHS providers to assess different ways of working and prepared a new policy and procedure which would ensure surgeons participated in the sign in phase of the process. A draft policy and more comprehensive documentation records had been devised and were awaiting sign off and implementation which would be adopted trust wide. Following the inspection, we learned that managers had expedited the implementation of this new process and its implementation was being trialled at Halton Hospital theatres the week following our inspection. This was a positive step and it was believed this this would greatly strengthen the safer surgery processes.

The service undertook observational audits of the World Health Organisation checklist and the ‘five steps to safer surgery’ and these showed close to 100% compliance. The theatres administrative computer system also ensured that procedures could not proceed without stages of
the process being complete. During our inspection we observed that the time out, sign out and post-operative debrief were undertaken to a good standard. We also found the theatres wide safety huddle and briefing for the large team and associated documentation was completed to a high standard.

The service had implemented Local Safety Standards for Invasive Procedures based on National Safety Standards for Invasive Procedures. These were ratified by the trust quality and safety governance processes and were reviewed regularly as processes changed.

Upon admission to the ward patients were assessed for potential risk. These included nutritional, pressure ulcer, falls and venous thromboembolism. These were completed on the electronic records system. We were advised that it was practice that day case patients were not formally risk assessed upon admission. This was due to their low risk status and because they would not routinely be staying long in the department. We were advised that risk assessments would be done if the nurse’s clinical judgement suggested this was necessary or if the patient became an inpatient. Managers in the service considered this position and decided to implement a modified risk assessment tool for day case patients to ensure documentation was in line with best practice.

Where a patient was identified as being at risk, we saw that measures were put in place to ensure risks were highlighted and mitigated. We also saw that risk assessments were reviewed appropriately. We saw that patients assessed to be at risk of pressure ulcers were given pressure relieving devices such as mattresses and cushions. We saw that mechanical and or medicinal venous thromboembolism prophylaxis were prescribed such as anti-embolism stockings and sub cutaneous medicines. We also saw that for those identified as being at risk of falls, measures such as enhanced support and falls alarms were provided. We saw ‘call don’t fall’ posters displayed in patient areas on the wards.

During our inspection we did note some inconsistencies around the documentation of risk assessments on the Cheshire and Merseyside treatment centre inpatient ward. We looked into this and we found the issues were more to do with occasional lapses in documentation rather than in the implementation of measures to reduce risk. Such as failing to document appropriate mattresses were in use for patients highlighted as being at risk. We raised these with managers who said this would be rectified.

The risk of patient deterioration was identified through a process of monitoring observations and vital signs. These were formulated into a scoring system called a ‘national early warning score’ (NEWS). An early warning score is a recognised and widely used system to quickly determine how poorly a patient may be and this is matched against an appropriate clinical response depending on the score. Staff were able to explain how the process worked and what action to take when scores indicated a patient’s condition was deteriorating. The records were checked showed that raised scores were acted upon appropriately, or where escalation principles were not followed, the rationale was documented, such as an immediately post-operative orthopaedic patient whom would be expected to have vital signs that deviated from range due to the medicine given during the operation and following the operation.

The latest national early warning score called NEWS2 had been implemented in the trust and this had been audited in February 2019 and again in March 2019. The performance of the Cheshire and Merseyside treatment centre was one of the best across the trust. However, in the March audit the service had deteriorated on three measures and improved on one measure. Action plans were in place and the audit is to be repeated.
Patients’ risk during surgery was assessed at pre-operative clinic which was a nurse led service. The assessment nurses took the patient’s past medical history, undertook a clinical examination and determined if any further tests or information was needed prior to surgery. The pre-operative clinic also had some designated anaesthetist led appointments for those patients who were potentially at greater risk and who needed a consultation with an anaesthetist prior to their surgery. The pre-operative team initiated enhanced recovery protocols for relevant procedures and educated patients on the programme and what they needed to do. The pre-operative clinic also assessed patients for their mental health needs and any phobias or anxiety. They also assessed for any individual needs. The pre-operative assessment clinic assessed all surgical patients for the whole of the trust at the site at Halton. They determined if the patient was fit for surgery and if they were suitable for surgery at the Halton site.

The general surgery ward (B4) had a middle grade doctor on duty between the 8am and 5pm. Between 5pm and 8am the following morning, medical and emergency assistance was provided by the ‘hospital at night’ team, they held emergency bleeps and responded to any calls for medical assistance and emergencies in the hospital. This comprised of a resident medical officer doctor who was trained in advanced life support and there was also a hospital co-ordinator who was nurse trained in advanced life support.

All band six and above nurses in the surgery services, were trained in advanced life support and the ward B4 ensured that a band six or above nurse was on duty at all times. This meant there was always a team member with advanced life support skills on duty on ward B4.

On the Cheshire and Merseyside treatment centre inpatient ward, although all band six and above nurses were trained in advanced life support, however there was not always a band six or above nurse was on duty at all times. There was however a resident medical officer present on the ward at all times. The resident medical officer was able to attend to patients who showed signs of deterioration and who needed a medical review.

As the hospital was classed as a ‘cold’ site, which means it did not have an accident and emergency department nor an intensive or high dependency care unit. This site only cared for patients whose admission was planned and who had been assessed as low risk and therefore suitable to be treated at this hospital. Any patient who deteriorated and who needed emergency treatment was transferred by an emergency ambulance to the Warrington site for emergency care. Staff described a zero tolerance to deteriorating patients and stated if they had any doubt that a patient was not okay they would not hesitate to implement the transfer protocol and transfer patients. They also described that there would be no challenge or repercussions for staff if they felt that it was in the best interests of patients to be transferred.

A review of patients who had been transferred as emergencies to Warrington for treatment had been reviewed by managers. They checked to see if the patient had suffered any harm or raised risk, if their transfer could have been predicted and if it was actually the best course of action. Managers stated the finding assured them the outcomes for patients were not affected and the processes worked well to keep patients safe.

Consultant surgeons were available by telephone outside of core hours should they be required for advice or support.

Allergies were discussed with patients upon admission to the wards and these were noted in records. In the records we checked we found that all had allergy status of the patient recorded within the records.
Emergency pull cords were available in areas where patients were left alone, such as toilets and changing areas. Call bells were available on wards and we saw that these were placed within reach of patients’ hands to help make sure they could access help should it be required.

Theatres had difficult airways and emergency trolleys available and staff had practised scenarios to ensure they were familiar with possible emergency situations.

**Nurse staffing**

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

**Planned vs actual**

**Trust level**

The trust has reported their nursing staffing numbers below, by ward, from April 2017 to March 2018 and from April to November 2018 in surgery at trust level. The service had a fill rate of 90.8% from April 2017 to March 2018 which decreased to 83.6% in the latest period. Actual staff WTE has stayed similar but the trust have increased their planned staff WTE.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>B4</td>
<td>12.4</td>
<td>10.5</td>
</tr>
<tr>
<td>Day Case Unit</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Elective Orthopaedic Ward</td>
<td>25.0</td>
<td>22.2</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>3.5</td>
<td>3.5</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>19.0</td>
<td>17.6</td>
</tr>
<tr>
<td>Surgical Assessment Unit</td>
<td>7.5</td>
<td>5.8</td>
</tr>
<tr>
<td>Theatres</td>
<td>82.0</td>
<td>75.4</td>
</tr>
<tr>
<td>Ward A5</td>
<td>18.9</td>
<td>17.6</td>
</tr>
<tr>
<td>Ward A6</td>
<td>20.7</td>
<td>17.1</td>
</tr>
<tr>
<td>Ward A9</td>
<td>20.6</td>
<td>20.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>209.6</strong></td>
<td><strong>190.2</strong></td>
</tr>
</tbody>
</table>

**Halton Hospital**

The trust has reported their nursing staffing numbers below, by ward, from April 2017 to March 2018 and from April to November 2018 in surgery at Halton Hospital. The service had a fill rate of 87.4% from April 2017 to March 2018 which decreased to 74.0% in the latest period. Actual staff WTE has stayed similar but the trust have increased their planned staff WTE.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>B4</td>
<td>12.4</td>
<td>10.5</td>
</tr>
<tr>
<td>Day Case Unit</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Cheshire and Merseyside Treatment Centre

The trust has reported their nursing staffing numbers from April 2017 to March 2018 and from April to November 2018 in surgery at Cheshire and Merseyside Treatment Centre. The service had a fill rate of 89.0% from April 2017 to March 2018 which decreased to 79.9% in the latest period.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Elective Orthopaedic Ward</td>
<td>25.0</td>
<td>22.2</td>
</tr>
</tbody>
</table>

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

During our inspection we found that the wards had sufficient staff on duty to protect patients from avoidable harm. We also found that there was sufficient flexibility in the system to allow for the accommodation of an unpredictable event such as staff sickness or the care of a patient with higher acuity levels than planned for. As ward managers were supernumerary, they could assist staff when unexpected events occurred. Staff reported that they could provide the care they wanted to patients and did not report concerns over staffing levels. Patients we spoke with stated their need were responded to in a timely way and did not report issues with delays in gaining attention or assistance.

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

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

Turnover rates

From December 2017 to November 2018, the trust reported a turnover rate of 13.6% in surgery. This is slightly higher than the trust target of 13%. A breakdown by site can be found below.

- Halton Hospital surgery department: 15.7%
- Cheshire and Merseyside Treatment Centre: 17.8%

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

Managers told us that the turnover rates at Halton and the Cheshire and Merseyside treatment centre were mainly due to staffing gaining promotion. Some staff left the service due to not liking being moved to work at the Warrington site. This information was captured by feedback provided by staff leaving the service. Managers also told us they did not have a problem attracting staff to take up employment in the service.
Sickness rates

From December 2017 to November 2018, the trust reported a sickness rate of 6.5% in surgery. This is higher than the trust target of 4.3%. A breakdown by site can be found below.

- Warrington Hospital surgery department: 5.4%
- Halton Hospital surgery department: 7.5%
- Cheshire and Merseyside Treatment Centre: 10.8%

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

Bank and agency staff usage

Halton Hospital

From December 2017 to November 2018, the trust reported 1,901 (1.9%) bank hours and 563 (0.6%) agency hours were filled by qualified nursing staff in surgery at Halton Hospital. There were 53 hours (0.1%) that were left unfilled. The theatres at Halton were the only area to have bank and agency use and unfilled hours.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>B4</td>
<td>24,040</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Day-case unit</td>
<td>8,925</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Theatres</td>
<td>67,497</td>
<td>1,901</td>
<td>2.8%</td>
<td>563</td>
</tr>
<tr>
<td>Total</td>
<td>100,462</td>
<td>1,901</td>
<td>1.9%</td>
<td>563</td>
</tr>
</tbody>
</table>

During the same period, the trust reported 152 (0.2%) bank hours and no agency hours were filled by nursing assistants in surgery at Halton Hospital. There were 10 hours (0.0%) that were left unfilled. The theatres at Halton were the only area to have bank use and unfilled hours.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Ward/Unit</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>NOT filled by bank/agency usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4</td>
<td>21,528</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Day Case Unit</td>
<td>8,415</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Theatres</td>
<td>45,256</td>
<td>152</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>75,200</td>
<td>152</td>
<td>0</td>
</tr>
</tbody>
</table>

Cheshire and Merseyside Treatment Centre

From December 2017 to November 2018, the trust reported 1,732 (3.7%) bank hours and 21 (0.0%) agency hours were filled by qualified nursing staff in surgery at Cheshire and Merseyside Treatment Centre. There were 312 hours (0.7%) that were left unfilled.
A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Elective Orthopaedic Ward</td>
<td>47,108</td>
<td>1,732</td>
<td>3.7%</td>
<td>21</td>
</tr>
</tbody>
</table>

During the same period, the trust reported 4,718 (18.3%) bank hours and no agency hours were filled by nursing assistants in surgery at Cheshire and Merseyside Treatment Centre. There were 864 hours (3.4%) that were left unfilled.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Ward/Unit</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>NOT filled by bank/agency usage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Elective Orthopaedic Ward</td>
<td>25,731</td>
<td>4,718</td>
<td>18.3%</td>
</tr>
</tbody>
</table>

The trust reports that it “continues to strive to reduce bank and agency reliance for all services. Non-qualified nurse agency spend is almost non-existent and bank usage is tackled through our recruitment drives to fill our vacancies.”

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

The surgical services at Halton and Cheshire and Merseyside treatment centre had low use of bank and agency staff. Where they did have to use bank staff they used their own staff from the ward who were familiar with the work and the area. Only on very rare occasions would they use a bank or agency member of staff who was new to the areas. On these occasions they received an induction and familiarisation session before starting work.

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

Planned vs actual

Trust level
The trust has reported their medical staffing numbers below, from April 2017 to March 2018 and from April to November 2018 in surgery at trust level. The service had a fill rate of 66.4% from April 2017 to March 2018, which is similar to the 65.0% fill rate reported in the latest period.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Day Case Unit</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Halton Hospital

The trust has reported their medical staffing numbers for the day case unit at Halton. From April 2017 to March 2018 the trust reported no staff planned. From April to November 2018 the trust has 0.5 WTE staff planned but no actual staff in place.

Please note: The trust report that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. Where possible, the trust has associated the departments to services/wards but for theatre staff the trust has allocated to the Warrington site based on where the majority of work is completed.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Day Case Unit</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Cheshire and Merseyside Treatment Centre

The trust has reported their medical staffing numbers below from April 2017 to March 2018 and from April to November 2018 in surgery at Cheshire and Merseyside Treatment Centre. Fill rates are similar in both periods with the latest period, April to November 2018, having a fill rate of 64.8%.

Please note: The trust report that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. Where possible, the trust has associated the departments to services/wards but for theatre staff the trust has allocated to the Warrington site based on where the majority of work is completed.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Elective Orthopaedic Ward</td>
<td>34.3</td>
<td>22.6</td>
</tr>
</tbody>
</table>

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

Surgical staff at Halton worked across both sites and so analysis of figures does not give an indication of whether staffing levels were satisfactory. Managers in the clinical business units reported fluctuations in the allocation of junior doctors from the deanery but had plans to use advanced nurse practitioners where possible.

The service had lower (better) than England average numbers of cancelled operations and surgical staff did not report difficulties in securing surgeons to complete operating lists. Managers
reported some difficulties in recruiting certain types of surgical speciality surgeons, however, they had plans in place to deal with such issues such as collaboration with neighbouring trusts.

The Halton site employed the services of resident medical officers to undertake much of the routine medical work on wards. The resident medical officers were recruited through a third party external provider. The external provider was responsible for ensuring and checking general medical council registration and training, health and background checks, revalidation and performance monitoring. Evidence of such was provided to the service. All new staff received a trust and local induction. They had access to and training on trust electronic such as patient records, referral systems, incident reporting systems and diagnostic results and requests.

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

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

**Turnover rates**

From December 2017 to November 2018, the trust reported a turnover rate of 12.1% in surgery. This is lower than the trust target of 13%.

The trust report that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. Where possible, the trust has associated the departments to services/wards but in most cases the trust has allocated the site based on where the majority of work is completed. This means that the trust is unable to break down the turnover data for medical staff at Warrington and Halton Hospitals.

- Warrington/Halton Hospital surgery departments: 11.0%
- Cheshire and Merseyside Treatment Centre: 16.6%

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

**Sickness rates**

From December 2017 to November 2018, the trust reported a sickness rate of 0.9% in surgery. This is lower than the trust target of 4.3%.

The trust report that medical staff in surgery work across both Warrington and Halton sites to allow for flexibility. Where possible, the trust has associated the departments to services/wards but in most cases the trust has allocated the site based on where the majority of work is completed. This means that the trust is unable to break down the sickness data for medical staff at Warrington and Halton Hospitals.

- Warrington/Halton Hospital surgery departments: 1.0%
- Cheshire and Merseyside Treatment Centre: 0.6%
Bank and locum staff usage

Trust level

From December 2017 to November 2018, the trust reported 16,564 (5.1%) bank hours and 7,856 (2.4%) locum hours were filled by medical staff in surgery at trust level. There were 632 (0.2%) hours that were left unfilled by medical staff.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Site/ward</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Locum Usage</th>
<th>NOT filled by bank or locum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Elective orthopaedic ward</td>
<td>63,144</td>
<td>867</td>
<td>1.4%</td>
<td>2,119</td>
</tr>
<tr>
<td>Day-case unit</td>
<td>319</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>46,936</td>
<td>63</td>
<td>0.1%</td>
<td>0</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>33,644</td>
<td>3,542</td>
<td>10.5%</td>
<td>539</td>
</tr>
<tr>
<td>Theatres</td>
<td>180,161</td>
<td>12,091</td>
<td>6.7%</td>
<td>5,198</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>324,204</strong></td>
<td><strong>16,564</strong></td>
<td><strong>5.1%</strong></td>
<td><strong>7,856</strong></td>
</tr>
</tbody>
</table>

The trust reported an additional 19,029 central bank hours worked which were not able to associate with a specific speciality.

Halton Hospital

From December 2017 to November 2018, the trust reported 319 available hours at the day case unit at Halton Hospital, although there was no reported bank or locum usage and no hours left unfilled by medical staff.

Cheshire and Merseyside Treatment Centre

From December 2017 to November 2018, the trust reported 867 (1.4%) bank hours and 2,119 (3.4%) locum hours were filled by medical staff in surgery at Cheshire and Merseyside Treatment Centre. There were 320 (0.5%) hours that were left unfilled by medical staff.

A ward breakdown is shown below:

<table>
<thead>
<tr>
<th>Site/ward</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Locum Usage</th>
<th>NOT filled by bank or locum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Elective orthopaedic ward</td>
<td>63,144</td>
<td>867</td>
<td>1.4%</td>
<td>2,119</td>
</tr>
</tbody>
</table>

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

Staffing skill mix
In October 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was higher. This trust had a higher proportion of middle career medical staff and lower proportion of registrar group than the England average.

**Staffing skill mix for the whole time equivalent staff working at Warrington and Halton Hospitals NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>47%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>19%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>17%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>16%</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 and those records were up-to-date. Patient records were in both electronic and paper form. The paper records contained various documents such as historical medical records, surgical pathways, peri-operative documentation, diagnostic results and consent forms. There were also some ‘end of bed’ records containing nursing documentation such as observation charts, fluid balance charts and care and comfort records. Prescription and medicines administration charts, risk assessments, care plans, pre-operative assessment records and daily notes were recorded electronically.

We found that patient records were stored in records cabinets which were secured with key coded locks to protect them from unauthorised access. Records maintained on computer systems were limited to those with authorised access using passwords and photographic computer access cards.

**Medicines**

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

During our inspection of the wards we found that medicines, including controlled drugs and intravenous fluids were stored safely and in line with best practice guidance and trust policy. We reviewed records that demonstrated that staff carried out daily checks on controlled drugs and stocks to ensure medicines were reconciled correctly. During the inspection we also checked a...
sample of controlled drugs on each ward and department and found the stock balances correlated with the registers. We also saw that the controlled drugs book showed evidence that two staff members had signed for controlled drugs. We saw correct recording of ‘wasting’ of controlled drugs, where the full contents of a vial were not prescribed. Medicines with a shortened expiry once opened, had the date opened recorded.

However, during our inspection we observed one instance where controlled drugs were not handled appropriately. We observed a vial of controlled drugs was left unattended in the anaesthetic room, we also observed a member of staff drawing up the drug with no witness. This was not in line with trust policy nor national guidance. This incident was highlighted to the trust who took appropriate action.

We found that medicines requiring cool storage were kept in medicines refrigerators and found that the recording of temperatures of those refrigerators was being undertaken appropriately which was able to identify if the refrigerator had been out of appropriate temperature range and so it was ensured that medicines remained safe to use. There was also recording of ambient room temperatures, to check medicines had not been exposed to extreme temperatures above 25°C, which may have affected their effectiveness.

Venous thromboembolism (VTE) risk assessments were completed for patients and medicines prescribed accordingly.

During the inspection we saw that a medicines reconciliation had been completed for some of the records reviewed. The National Institute for Health and Care Excellence guidance recommends a medicines reconciliation should be completed within 24 hours of admission. The pharmacy department report the medicines reconciliation rate was in the region of 26-28%, which is below the expected rate of 90%. There were no pharmacy staff available to complete reconciliations at weekends, or outside of core hours.

Pharmacy staff provided a weekly medicine top up service to the wards; expiry dates were checked by the staff. There was no evidence of any out of date medicines.

Medicines management policies and procedures were available via the trust intranet, all staff were able to access these easily.

A critical medicine is a medicine which must be given urgently, that is it should be given immediately or within two hours. Examples of critical medicines are anti-epileptics and anti-Parkinson medicines. The service had a critical medicines policy in place, however staff we spoke with were not aware of this policy, nor could they describe what critical medicines were.

An antimicrobial pharmacist was in place, they were responsible for reviewing antibiotic prescribing. The microbiology department also supported with antibiotic prescribing through the monitoring and identification of samples. Therapeutic monitoring of bloods was completed as required.

The service used an electronic medicine prescribing and administration system, this supported staff record the start, stop or review dates and the indication for use documentation for antibiotics, these were required sections of the record. If a patient had an allergy this was highlighted in red on the system. The system also prevented medicines being given too soon and highlighted interactions between medicines.

When a patient was being discharged information was shared with their local community pharmacy. This relatively new initiative had been received positively and enabled better current knowledge by community pharmacists following potential changes to medicines during the
patients’ hospital stay. It also provided benefits for patients such as better support, counselling and understanding of their medicines gained through a better relationship with their community pharmacist.

There was access to a medicine store outside of core hours and during the weekend. This was controlled by the hospital site manager. There was also a system in place whereby staff could check and locate whether medicines they required were in stock on another ward through the trust intranet. It was also possible to obtain medicines from the Warrington site if needed. A resident medical officer and a nurse practitioner were on site and could prescribe medicines out of hours. There was access to on-call pharmacist out of hours.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

**Never Events**

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

From February 2018 to January 2019, the trust reported no incidents classified as never events for surgery.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in surgery at Halton and Cheshire and Merseyside treatment centre, which met the reporting criteria set by NHS England from February 2018 to January 2019.

(Source: Strategic Executive Information System (STEIS))

The service used an electronic incident reporting and management system. Reports were submitted by completing sections of an electronic form. The person reporting was notified of the outcome of any incident they reported. Staff stated they understood the system, it was easy to use and they would report incidents.

We saw that the service was keen to learn from incidents and any instances when things did not go as planned. We saw an improvement in the number of never events since our last inspection. We saw that practices to improve safety in the operating theatres had been introduced and further changes were ongoing. We saw that learning and changes were made following incidents, such as changes made to the pre-operative assessment processes to improve the possibility of information being missed by the theatres listing teams.
A trust wide safety huddle and morning safety brief was undertaken every morning with representatives from all wards and departments. This was circulated by email to every member of staff in the trust every morning and shared safety and time critical information to enable knowledge and learning from incidents, safety issues, ‘hot topic of the week’, ‘bright spots’ and any ‘HALT moments’. Halt moment were issues that required immediate attention and potentially intervention to maintain satisfactory services. We saw that topics of the week while we were on inspection was pain monitoring tools. There was discussion and learning around this topic in the bulletin.

Booklets entitled ‘learning to improve’ were circulated trust wide, we saw copies of these booklets on surgical wards and departments. Topics included were serious incidents, falls, learning from the mortality review group, complaints, tissue viability and learning from medicine incidents.

Safety thermometer

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

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 seven new pressure ulcers, one fall with harm and 10 new urinary tract infections in patients with a catheter from January 2018 to January 2019 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Warrington and Halton Hospitals NHS Foundation Trust**
During the inspection we observed that safety thermometer information was being displayed in a prominent place on the wards we visited. The information was updated regularly to keep patients and visitors informed about the ward performance.

We were advised that pressure ulcers, falls and catheter acquired urinary tract infections were very rare at Halton hospital. This was due to the short lengths of stay for surgical patients and that patients were classed as lower risk.

Risk assessments for pressure ulcers, falls and venous thromboembolism were completed for each inpatient upon admission and reviewed as appropriate throughout their stay. Documentation that we checked confirmed this was done appropriately and actions taken where risks were identified such as using a pressure relieving mattress, venous thromboembolism prophylaxis or implementing a falls care plan. The service would implement risk reduction plans such as fall reduction care plans which might include, cohorting at risk patients; which meant higher risk patients were cared for in the same bay, bay tagging; which meant that there was always a member of staff present in the bay at all times and the use of slipper socks; which had no slip grips to reduce the chances of slipping.
Is the service effective?

Evidence-based care and treatment

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

National Institute for Health and Care Excellence, evidence based practice guidance, alerts and updates were reviewed for changes by the National Institute for Health and Care Excellence coordinator who directed the relevant clinicians to the appropriate area on the National Institute for Health and Care Excellence website in order to complete a baseline tool. Clinical leads and lead nurses then ascertained the impact on their scope of practice and if changes in the care and treatment processes were to be implemented. The service aimed to ensure that any changes were implemented within 90 days. The clinical governance group and clinical business unit triumvirate members reviewed and actioned any changes. Any deviation or planned departure from the guidance was risk assessed was agreed through the governance structures and was included on the relevant clinical business unit risk register.

Care pathways and care bundles such as hip and knee replacements, breast surgery, upper and lower gastrointestinal surgery followed National Institute for Health and Care Excellence guidance and were followed by surgical teams. Other best practice and guidance around enhanced recovery and fasting for surgery.

The service followed best practice in relation to the pre-operative assessment processes; this ensured patient risk was identified and minimised as much as possible. It also aimed to optimise patients for surgery to provide the best possible outcomes.

The Cheshire and Merseyside treatment centre ran a ‘joint school’ which was in keeping with guidance around the education and patient involvement for patient undergoing hip and knee replacement surgery. This initiative was well received by patient and produced better outcomes for patients.

Nutrition and hydration

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

The inpatient patient’s records we checked included all appropriate assessments for nutritional intake which highlighted those at risk of malnutrition. We observed that risk assessments were reviewed at appropriate intervals. We found patients on fluid balance charts had these completed and updated appropriately.

Wards had access to a dietician during the day who were able to provide advice and support for those people who were highlighted to be at risk of dehydration or malnutrition. We did not see any examples of this during our inspection as we did not encounter a patient who fitted these criteria. However, we learned that if a risk was identified, staff were able to refer the patient for a dietician review electronically and the dietician who was based at Warrington could review the patient as appropriate.

Surgical wards had access to a diabetes specialist nurse who was available for advice for patients and staff. We saw evidence that blood glucose monitoring was undertaken at regular intervals.
Patients told us they were satisfied with the quality and choice of food and that was provided.

**Pain relief**

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

Surgical wards and theatres recovery areas assessed pain as part of the patient assessment and observations process. The service had pain monitoring tools in place and this was documented alongside clinical observations. If pain was identified an appropriate response such as administering pain relief or additional relief was implemented. This response would be reviewed to ensure that it had been effective and this would be documented accordingly.

Staff also had access to a pain team with specialist pain control nurses within core working hours, they were available upon referral and were based at Warrington hospital. Out of hours and at weekends, pain advice could be sought from the on-call anaesthetist at Warrington.

Pain was discussed as part of the pre-operative assessment process and at joint school as part of the preparation of patients for their surgery. Any potential issues with pain were identified and if appropriate the anaesthetist would review the patient and advise accordingly.

The patients we spoke with on inspection reported good attention to pain levels and stated the responses by staff to their pain levels was timely.

**Patient outcomes**

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

**Relative risk of readmission**

**Trust level**

From September 2017 to August 2018, all patients at the trust had a similar to expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a much higher than expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.
Elective Admissions – Trust Level

- General surgery patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- Upper gastrointestinal surgery patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level

- Urology patients at Halton General Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Halton General Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at Halton General Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

Halton General Hospital

From September 2017 to August 2018, all patients at Halton General Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at Halton General Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Halton General Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at Halton General Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
Elective Admissions - Halton General Hospital

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

Non-Elective Admissions - Halton General Hospital

No non-elective surgery takes place at Halton General Hospital.

(Source: Hospital Episode Statistics - HES - Readmissions (September 2017 – August 2018))

The service was aware of the readmission statistics around urology patients and had undertaken a project to understand the reasons for this and created an action plan to reduce readmissions. The service reported that in the period since the above data was collected there has been a significant reduction in the readmission rates for urology patients. They also suggested that as they had very high numbers of days case patients and only low numbers of inpatient stays, when a patient is readmitted, the data and percentages were affected dramatically, whereas the numbers of patients affected were very small.

National Hip Fracture Database 2018

The Halton and Cheshire and Merseyside treatment centre services did not submit data to the National Hip Fracture Database as they did not treat this classification of patient on this site.

Bowel Cancer Audit 2017

The table below summarises Warrington and Halton Hospitals NHS Foundation Trust’s performance in the 2018 National Bowel Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national aspirational standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment <em>(Proportion of eligible cases included in the audit)</em></td>
<td>45.4%</td>
<td>Poor (less than 50%)</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted post-operative length of stay &gt; 5 days after major resection <em>(A prolonged length of stay can pose risks to patients)</em></td>
<td>Not reported</td>
<td>N/A</td>
<td>No current standard</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></th>
<th>Not reported</th>
<th>N/A</th>
<th>No current standard</th>
</tr>
</thead>
</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></th>
<th>23.5%</th>
<th>Within expected range</th>
<th>No current standard</th>
</tr>
</thead>
</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></th>
<th>Not reported</th>
<th>N/A</th>
<th>No current standard</th>
</tr>
</thead>
</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></th>
<th>52.1%</th>
<th>Within expected range</th>
<th>No current standard</th>
</tr>
</thead>
</table>

(Source: National Bowel Cancer Audit)

### National Vascular Registry 2017

The trust did not participate in the National Vascular Registry (NVR) audit as they did not treat this classification of patient on this site.

(Source: National Vascular Registry)

### National Oesophago-gastric Cancer Audit 2018

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

The table below summarises Warrington and Halton’s Hospitals NHS Foundation Trust’s 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>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level metrics (Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>0% to 40%</td>
<td>Worse</td>
<td>No current standard</td>
</tr>
<tr>
<td>Age and sex adjusted proportion of patients diagnosed after an emergency admission (Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)</td>
<td>12.9%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality rate (Proportion of patients who die within 90 days of their operation)</td>
<td>Not eligible</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
<tr>
<td>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.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of patients treated with curative intent in the Cancer Alliance (Proportion of patients receiving treatment intended to cure their cancer)</td>
<td>40.0%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Oesophago-Gastric Cancer Audit 2018)

**National Emergency Laparotomy Audit 2017**

The Halton and Cheshire and Merseyside treatment centre services did not submit data to the National Emergency Laparotomy Audit database as they did not treat this classification of patient on this site.

**National Ophthalmology Database Audit 2018**

(Audit of patients undergoing cataract surgery)

### Metrics (Audit measures)

<table>
<thead>
<tr>
<th>Trust-level metrics</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case ascertainment</strong>&lt;br&gt;(Proportion of eligible cases included in the audit)</td>
<td>89.4%</td>
<td>Not applicable</td>
<td>No current standard</td>
</tr>
<tr>
<td><strong>Risk-adjusted posterior capsule rupture rate</strong>&lt;br&gt;(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>0.8%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td><strong>Risk adjusted visual acuity loss</strong>&lt;br&gt;(The most important outcome following cataract surgery is the clarity of vision)</td>
<td>No data available</td>
<td>No data available</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Ophthalmology Database Audit 2018)

### National Joint Registry 2018

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

The table below summarises the Cheshire and Merseyside treatment centre’s performance in the 2018 National Joint Registry.

### The Cheshire and Merseyside Treatment Centre

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trust-level</strong>&lt;br&gt;Proportion of patients consented to have personal details included <em>hips, knees, ankles and elbows</em>&lt;br&gt;(Patient details help ‘track and trace’ 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)</td>
<td>99.6%</td>
<td>Better</td>
<td>✗</td>
</tr>
<tr>
<td><strong>Hospital</strong>&lt;br&gt;Risk-adjusted 5-year revision ratio (for hips excluding</td>
<td>0.5</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
</tbody>
</table>
tumours and neck of femur fracture)  
(Proportion of patients who need their hip replacement ‘re-doing’)  

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)  

| Hospital level: Knees | Risk-adjusted 5-year revision ratio (for knees excluding tumours)  
(Proportion of patients who need their knee replacement ‘re-doing’) | 0.83 | Within expected range | ✓  
| Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours)  
(Proportion of patients who die within 90 days of their operation) | 1.17 | Within expected range | ✓  

(Source: National Joint Registry 2018)

National Prostate Cancer Audit

The table below summarises Warrington and Halton Hospitals NHS Foundation Trust’s performance in the 2017 National Prostate Cancer Audit.

| Metrics  
(Audit measures) | Hospital performance | Comparison to other trusts | Meets national standard? |
|------------------|----------------------|---------------------------|-------------------------|
| Men with complete information to determine disease status  
(This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body) | 92.3% | N/A | ✓ |
| 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 | No data available | N/A | No current standard |
### Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy

| Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy | No data available | N/A | No current standard |

(Complications following surgery may reflect the quality of surgical care)

### Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy

| Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy | No data available | N/A | No current standard |

(External beam radiotherapy uses high-energy beams to destroy cancer cells)

(Source: National Prostate Cancer Audit 2017)

### Patient Reported Outcome Measures

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

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

![Graph showing proportions of patients reporting improvement or worsening after different procedures]

In 2016/17 performance on groin hernias was worse than the England average.

For varicose veins, performance was worse than the England average for Aberdeen varicose vein questionnaire and better for EQ-VAS and EQ-5D Index.

For hip replacements, performance was about the same as the England average.

For knee replacements, performance was about the same as the England average.

(Source: NHS Digital)

**Competent staff**

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

**Appraisal rates**

**Trust level**

The trust target for appraisals was 85% by the end of the financial year. From April 2018 to December 2018, 70.4% of staff within surgery at the trust received an appraisal.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Eligible staff</th>
<th>Completed appraisals</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>140</td>
<td>108</td>
<td>77.1%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>183</td>
<td>136</td>
<td>74.3%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>17</td>
<td>12</td>
<td>70.6%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>83</td>
<td>54</td>
<td>65.1%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>40</td>
<td>24</td>
<td>60.0%</td>
</tr>
</tbody>
</table>
Other Qualified Scientific, Therapeutic & Technical (ST&T) staff & NHS infrastructure support

<table>
<thead>
<tr>
<th>Service</th>
<th>Eligible</th>
<th>Completed</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical (ST&amp;T) staff</td>
<td>37</td>
<td>22</td>
<td>59.5%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>10</td>
<td>3</td>
<td>30.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>510</strong></td>
<td><strong>359</strong></td>
<td><strong>70.4%</strong></td>
</tr>
</tbody>
</table>

**Halton Hospital**

The trust target for appraisals was 85% by the end of the financial year. From April 2018 to December 2018, 71.9% of staff within surgery at Halton Hospital received an appraisal.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Eligible</th>
<th>Completed</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>31</td>
<td>26</td>
<td>83.9%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical (ST&amp;T) staff</td>
<td>16</td>
<td>12</td>
<td>75.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>41</td>
<td>25</td>
<td>61.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>89</strong></td>
<td><strong>64</strong></td>
<td><strong>71.9%</strong></td>
</tr>
</tbody>
</table>

**Cheshire and Merseyside Treatment Centre**

The trust target for appraisals was 85% by the end of the financial year. From April 2018 to December 2018, 77.8% of staff within surgery at Cheshire and Merseyside Treatment Centre received an appraisal compared to a trust target of 85%.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Eligible</th>
<th>Completed</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical (ST&amp;T) staff</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>16</td>
<td>15</td>
<td>93.8%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>19</td>
<td>14</td>
<td>73.7%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>16</td>
<td>10</td>
<td>62.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>54</strong></td>
<td><strong>42</strong></td>
<td><strong>77.8%</strong></td>
</tr>
</tbody>
</table>

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

Following the inspection, we were advised that the appraisal figures up to March 2019 were as follows against a trust target of 85%.

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Compliance</td>
<td>84.05%</td>
</tr>
<tr>
<td>Surgery Staff (both sites)</td>
<td>84.05%</td>
</tr>
<tr>
<td>Medical Compliance</td>
<td>100.00%</td>
</tr>
<tr>
<td>Nursing and Midwifery Compliance</td>
<td>78.07%</td>
</tr>
<tr>
<td>Other Compliance</td>
<td>83.67%</td>
</tr>
</tbody>
</table>

(Source: Additional data from Trust)
During our inspection we saw that managers monitored appraisal rates of their staff. We saw manual records which indicated that most staff within the service had received annual appraisals and that managers were aware when appraisals were due. We saw that managers acknowledged the importance of regular reviews and were aware of the reasons why staff had not had their appraisal such as long-term sickness or maternity leave.

We also saw that individual staff had competency based staffing records. We saw records were kept for staff training and competency on using a range of equipment and medical devices and that competency assessments were kept for surgical procedures and skills such as cannulation, medicines management and bladder scanning. There were preceptorship and training plans available to newly qualified nurses, nurses joining a new discipline, trainee nurses and associate nurses.

Staff told us there were opportunities for personal development, learning new skills and promotion. Managers told us that the main reason for staff leaving the service was due to employment opportunities and promotion. Many staff we spoke with were very experienced and had been with the trust for many years.

We observed some good learning and development sessions being provided to staff, we saw anaesthetists training trainee paramedics in theatres and registered nurses providing training to student nurses. We also saw that practice education trainers were present and visible on wards and departments.

**Multidisciplinary working**

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

The service utilised the skills of a range of disciplines in the delivery of care for patients. Staff told us these disciplines worked well together had a role in the planning and delivery of care for patients. Regular multidisciplinary team meetings were held on the wards and at senior levels to discuss patient care. Staff we spoke with from a range of specialisms and grades said they felt part of a team and were involved in patients’ care and treatment.

Occupational and physiotherapists worked with surgical and nursing staff in the joint school initiative to educate and optimise patients for joint replacement elective surgery patients. They also worked with patients to assist in their recovery and rehabilitation particularly on the inpatient ward at the Cheshire and Merseyside treatment centre.

There was access to a wide range of trust wide specialist staff such as dietitian, tissue viability, stoma nurses and mental health practitioners, who could be requested for advice and support. They were based at the Warrington site but were available for advice by telephone or a referral by electronic means.

**Seven-day services**

There was not always access to some services on site out of hours. However, if they were urgent these could be obtained from the Warrington site or patients could attend the Warrington site for certain procedures.

Due to the nature of the service provided there was limited access to diagnostics and investigatory procedures outside of core hours, in evening and at weekends. If necessary patients could be
transferred to Warrington for such investigations. Test samples where appropriate could be couriered to Warrington for processing if required. There was a blood testing device on site at Halton that could provide a limited range of blood tests.

Services were described as nurse led, as such there were no formal ward rounds and reviews by consultants. On the general surgery inpatients wards patients were not always reviewed post operatively by a consultant. If a review was required the nurse could request this from the ward based doctor or resident medical officer. Advice could be sought from the patient’s surgeon if required. Patients were discharged by nurses if they met the specified discharge criteria. Others required a review by a doctor to determine if they were fit for discharge.

On the orthopaedic ward consultants would generally review their patients immediately post operatively and could be reviewed if necessary by the resident medical officer. They could also be discharged by nurses if they met the specified discharge criteria or by a doctor if they did not meet the criteria.

Specialist staff such as dieticians and specialist nurses were not available at weekends. However, physiotherapy services were available at weekends but on a reduced capacity basis.

Pharmacists were available during core hours, Monday to Friday. Outside of the core hours during an evening, night and weekend there was an on-site medicines supply cupboard on site, there was a process where medicines could be obtained from other wards and if necessary medicines could be obtained from the Warrington site by courier. There was access to an on-call pharmacist outside core hours. There was however no emergency access to a pharmacy, this was because emergency patients were not cared for at Halton they would be transferred to the Warrington site.

**Health promotion**

Staff were able to offer health promotion advice such as smoking cessation, healthy diet and nutrition and had access to condition specific advice.

The service had access to smoking cessation and health promotion advice. This could be obtained through an electronic referral.

Staff in the service were encouraged to have a flu vaccination to help reduce the spread of flu between staff and patients. The service reported high rates of vaccination take up amongst staff.

Health and condition specific advice was provided in leaflets and posters which were in place at various points around the hospital.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

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

The trust had a consent policy in place which had been reviewed and updated regularly and was in keeping with current guidance. This was accessible to staff electronically. We saw that consent
for surgical treatment was taken where possible with the consultant surgeon as part of the outpatient consultation when referred for surgical treatment. Where this was not done, the consent was taken on the day of surgery.

A Mental Capacity Act and Deprivation of Liberty Safeguards operational procedure and a ‘Deprivation of Liberty Safeguards Application and Management’ standard operating procedure was in place. This was in keeping with best practice guidance. Staff received training in this area as part of the mandatory training programme. A deprivation of liberty means taking someone’s freedom away. A 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 their movement and impacts on their freedom. This may be done following a decision which confirms the care provided is in the best interests of the patient and that actions taken are the least restrictive. This is then authorised if appropriate by the local authority.

Staff we spoke with could describe the circumstances which might warrant the implementation of these policies and what they needed to do. They could describe the mental capacity assessment and best interest decisions. Due to the nature of the service provided at the site, staff told us it would be very unusual to have patients who lacked capacity or might be subject to a deprivation of liberty authorisation as they would be identified at the pre-operative assessment stage and directed to be cared for at Warrington.

However, we found one example of a patient who lacked capacity, but who had undergone a procedure at Halton under the digestive diseases team. Records showed that a procedure was attempted but this failed and was abandoned. It was determined that the patient may have lacked capacity. A second procedure was undertaken planned and this time an assessment of capacity was undertaken which determined the patient lacked the capacity to consent to treatment. There was, however, an absence of documentation of a best interests determination that the procedure the patient underwent was in their best interests and this procedure went ahead without this in place. This process was not in keeping with guidance on the treatment of persons who lacked capacity nor trust policy. When we reviewed the patient’s medical records there was a detailed history of previous procedures and capacity issues. This should have alerted the service to the patient’s needs around capacity and best interests.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that from April 2018 to December 2018, Mental Capacity Act (MCA) training was completed by 96.6% of staff in surgery compared to the trust target of 85%. Qualified nursing and health visiting staff had a completion rate of 92.7% and medical staff had a completion rate of 95.0%.

A breakdown of training completion by all staff by site is shown below:

- Halton Hospital: 100%
- Cheshire and Merseyside Treatment Centre: 93.0%

Over the same period Deprivation of Liberty Safeguards training was completed by 67.5% of staff in within surgery compared to the trust target of 85%. Qualified nursing and health visiting staff had a completion rate of 51.0% and medical staff had a completion rate of 61.0%.
A breakdown of training completion by all staff by site is shown below:

- Halton Hospital: 71.4%
- Cheshire and Merseyside Treatment Centre: 58.7%

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

The manager at the Cheshire and Merseyside Treatment Centre stated that there was a recording error with this data as all staff completed the Mental Capacity Act training at the same time as the Deprivation of Liberty Safeguards training, therefore the compliance data should be the same. The manager had raised their concerns to the training administration department and was awaiting resolution.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

During our inspection we observed positive interactions between staff and patients, staff demonstrated a courteous and polite approach and treated patients and those closest to them in a kind and caring manner. We also observed a calm and supportive atmosphere in wards and departments. Patients we spoke with expressed that staff very kind and compassionate and spoke highly of the care provided by staff.

We observed that staff protected the privacy and dignity of patients. Cubicle curtains were drawn and single room doors were closed during consultations and staff sought permission before entering such areas.

On our inspection we received many positive comments from patients. One patient said, “I can't fault the care I have received; everyone from the receptionist to the nurse, to the theatre staff and the doctors have made me feel so calm”. Other patients told us: “The staff are caring, they always have a smiley face and instil confidence in you”. And “Staff were absolutely brilliant, this was my first time in hospital since I was a child, I can't fault it”.

Friends and Family test performance

The Friends and Family Test response rate for surgery at Warrington and Halton Hospitals NHS Foundation Trust was 35%, which was better than the England average of 27% from January 2018 to December 2018.

Warrington Hospital (WH) had a response rate of 29%, whilst Halton Hospital (HH) had a response rate of 45%.

A breakdown by ward across all sites, including Cheshire and Merseyside Treatment Centre (CMTC) - located on Halton site - is shown below. There was a data issue in January 2018.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp Rate</th>
<th>Percentage recommended</th>
<th>Annual perf</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAU - SURGICAL ASSESSMENT UNIT - W</td>
<td>693</td>
<td>45%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>BH - DAYCASE - WARD 6A - H</td>
<td>657</td>
<td>50%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>DCM - DAYCASE - H - DAY CASE UNIT - H</td>
<td>563</td>
<td>26%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>CRM - DAYCASE - INPATIENT WARD - CMTC</td>
<td>532</td>
<td>51%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>OHC - DAYCASE - OPHTHALMIC DAY SURGERY - W</td>
<td>479</td>
<td>55%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>OOG - OPHTHALMIC DAYCARE - WARD 1C - W</td>
<td>441</td>
<td>21%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>TUSC - DAYCASE - ORAL SURGERY DEPARTMENT</td>
<td>396</td>
<td>60%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>CNHC - DAYCASE - DAY CASE TREATMENT CENTRE - CMTC</td>
<td>344</td>
<td>50%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>AS - WARD 6 - W</td>
<td>528</td>
<td>17%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>DOCC - DAYCASE - RADIOLOGY DAY CASE - W</td>
<td>163</td>
<td>21%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>CRM - INPATIENT WARD - CMTC</td>
<td>191</td>
<td>43%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>AS - WARD 6 - W</td>
<td>131</td>
<td>39%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Key
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.

The day case treatment centre at CMTC had the highest response rate with 85%, whilst ward A6 at Warrington Hospital had the lowest response rate with 17%.

(Source: NHS England Friends and Family Test)

Ward B4 at Halton hospital achieved an average recommendation rate of 95% for day case and 96% for inpatients from January 2018 to December 2018, their response rate was 29% for day case and 55% for inpatients.

The Cheshire and Merseyside treatment centre achieved an average recommendation rate of 99% for day case and 97% for inpatients from January 2018 to December 2018, their response rate was 85% for day case and 43% for inpatients.

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

During our inspection we saw that staff considered the emotional needs of patients in their care. We saw examples of staff in theatres supporting nervous and anxious patients and demonstrated a comforting and supportive approach. We also saw that staff were supportive to worried and anxious relatives and carers.

A chaplaincy service was available for spiritual, religious or pastoral support to those of all faiths and beliefs. There was a multi-faith prayer room on site at the hospital.

Bereavement advice and support were available to relatives and carers through the trust bereavement service.

Patients having joint replacement surgery told us that the joint school was particularly beneficial in giving information on how the surgery might impact them and those close to them and their wellbeing both socially and emotionally. Patients felt this enabled them and their loved ones to understand their needs better.

On our inspection we received comments from patients who said;

“Staff were brilliant, explained every little step in detail and gave me a lot of reassurance”,

“I was very nervous, I asked the consultant if I could go first and he did” and

“They allayed my fears”.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment.

The patients and relatives we spoke with told us they felt supported by members of staff. They reported that staff of all disciplines gave them time to express themselves and have their concerns listened to.

Patients told us they and those closest to them felt included in the decision making process and were actively included in decisions about their care and treatment. They said their individual needs were taken into account during the planning and delivery of their care and treatment.
Patients said they were given sufficient time to ask questions and have their questions answered. They stated they received clear and comprehensive information about their care and treatment in a way they understood. They felt this enabled them to make informed choices about treatment options. This was supported by what we saw during our visit.

On our inspection we received comments from patients who stated;

“The information pack provided at pre-op was very informative and put my mind at rest”,

“Pre-op was very helpful; I saw the anaesthetist who was brilliant and very patient in explaining the options, they gave me the confidence to try the epidural rather than a general anaesthetic”. and

“They helped to put my husband’s fears at ease”.
**Is the service responsive?**

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

The trust planned and provided services in a way that met the needs of local people.

The facilities and premises in which surgical care was provided were suitable for the services that were being delivered. The Cheshire and Merseyside treatment centre was modern and purpose-built with facilities which were bright, spacious, well-presented and well equipped. The location and parking options for patients were excellent. The facilities at the Halton Hospital site too were well located just a short walk from the car park and drop off points. Whilst the building was not as modern, it was bright and welcoming. Both wards had ready access to the operating theatres.

Patients we spoke with told us the facilities were excellent.

The service posted ‘you said, we did’ posters on notice boards and around the hospital to advise the public how they had reacted to their feedback and ideas and highlighted improvements made.

The service consulted with patient groups and community groups and the foundation trust membership regarding changes or restructuring to services.

**Meeting people’s individual needs**

The service took account of patients’ individual needs.

Patients were assessed for their individual needs as part of the pre-operative assessment process. Additional needs including patients demonstrating anxiety or nervousness, cultural requirements, mental health and cognitive needs, language or communication requirements were assessed. Pre-operative assessment staff determined if the patient’s needs could be met by the Halton site as well as determining if the patient was safe to be treated at the site.

Due to the type of services provided and the types of patients treated on site, the service was not often involved in the care of patients living with significant cognitive impairment or mental health issues. Patients living with dementia and learning disabilities or those with significant mental health conditions would more often be cared for at the Warrington site as it was deemed that they could better meet their needs. However, there was an awareness of the needs of such patients and there were occasions where such patients used the service.

The service used ‘This Is Me’ documentation to enable staff to be familiar with the individual needs of patients. They also involved the vulnerable patient teams for support and input. The trust recently established a trust wide alert system to make the senior nursing team aware when a patient with a learning disability was admitted. This prompted a welfare check and support for the ward, patient and their families with individualised care planning and assessments.

Patients who were identified as vulnerable such as 16 and 17 year olds, or those with individual needs were cared for in side rooms where this was deemed beneficial for them. Patients who were demonstrating or assessed as requiring greater support were put in side rooms or bays where they could be seen by staff and could be attended to more readily.

Most areas were suitable for patients using wheelchairs. There were wheelchair accessible toilets available around the hospital and in wards.

There were processes in place for people who needed translation and interpretation services. We saw that advice leaflets and information stated that they were available in other languages, the
advice was written in the most common languages and scripts advising how to gain copies. Whilst we did not see any stock copies of leaflets in any of the more common language spoken by members of the local community, we did see that leaflets and information was easy for staff to download and print out to give to patients. Furthermore, patients could access leaflets on the trust internet which they could obtain in different languages. However, we also saw that this system was not set up in the same was for patients to obtain copies of leaflets in accessible formats such as easy read and large text.

There was access to mental health support from another local NHS service provider if patients required a review and assessment.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Patients accessed the service for their surgical treatments through various routes, some from their GPs, some through outpatient specialist consultations. Although the service did not treat emergency patients, they did treat patients who had suffered an acute but not urgent injury and for whom their procedure could take place later and as such their admission was still pre-planned.

The service was designed to treat low risk patients quickly and efficiently thus relieving some of the burden from the acute site at Warrington. These patients benefitted from having their surgery at this location and were less likely to have their surgery delayed or cancelled due to emergency and priority cases. Patients we spoke with were very happy with the service provided. Many stated their wait was not long, some saying they were fitted into a list at short notice following the decision to have surgery and following their pre-operative assessment.

Admission times for elective surgery were staggered throughout the day so that patients did not have to wait for a long period once admitted to the ward. In addition, this prevented them from being fasted for periods longer that were necessary.

The musculoskeletal team operated a ‘hot list’ which took place for four days each month. This was a system whereby the service was able to accommodate some patients who were deemed may need an additional level of support following their surgery. The extra support enabled greater numbers of patients to be treated safely and eased pressure on waiting lists, to the benefit of all patients waiting for surgery.

The service did not offer evening and weekend appointments for the pre-operative assessment clinic or joint school. However, patients could change their appointments if those allocated were not convenient for them.

Allocations for operations were allocated by theatres scheduling teams on the basis of need and risk. Some patients’ operations were arranged at short notice following consultation and within a few days of their pre-operative assessment, which they found very convenient.

Lengths of stay at Halton were shorter (better) than England averages. The service cared for patients of lower risk and who were less likely to experience complications due to the nature of the service provided.

Referral to treatment times for elective patients was shorter (better) than the England averages and managers were looking at ways to improve this further. They were also looking at ways in which they better utilise the capacity at the site to benefit greater number of patients, both through
being treated on site, but also through creating capacity at the Warrington site for patients who
could not be treated at the Halton facilities themselves.

Discharge practices were effective. The service was largely nurse led, so if patients were stable
and met specified discharge criteria and their observation within specified parameters, nurses
discharged the patient. A standard operating procedure was in place for this practice and nurses
had received training to ensure they could safely discharge patients. Doctors discharged patients
who did not meet the criteria but whom were deemed safe to return home.

Staff referred patients to district nurses, dressings clinics and onward community services as
necessary. They were also provided with contact numbers for advice or advised to attend urgent
care services if needed. Patients received a copy of their discharge notices. A copy was also sent
to the patient’s community GP which helped them be aware of any changes in their medicine or
treatment.

Average length of stay (Remove trust level if this is a one site trust)

Trust Level – elective patients

From October 2017 to September 2018, the average length of stay for all elective patients at the
trust was 3.2 days, which is lower compared to the England average of 3.9 days.

- For trauma and orthopaedics elective patients at the trust was 3.5 days, which is similar
  compared to the England average of 3.8 days.
- For general surgery elective patients at the trust was 4.2 days, which is similar compared to
  the England average of 3.9 days.
- For urology elective patients at the trust was 2.4 days, which is similar compared to the
  England average of 2.5 days.

Elective Average Length of Stay – Trust Level

![Elective Average Length of Stay – Trust Level](image)

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

Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 4.8 days, which is the
same as the England average of 4.8 days.

- The average length of stay for general surgery non-elective patients at the trust was 3.5 days,
  which is similar compared to the England average of 3.7 days.
- The average length of stay for trauma and orthopaedics non-elective patients at the trust was
  9.5 days, which is higher compared to the England average of 8.6 days.
• The average length of stay for upper gastrointestinal surgery non-elective patients at the trust was 4.3 days, which is similar compared to the England average of 3.9 days.

**Non-Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This Trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4.8</td>
<td>3.6</td>
</tr>
<tr>
<td>General surgery</td>
<td>3.5</td>
<td>3.7</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>9.5</td>
<td>8.6</td>
</tr>
<tr>
<td>Upper Gastrointestinal Surgery</td>
<td>4.3</td>
<td>3.9</td>
</tr>
</tbody>
</table>

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

**Halton General Hospital - elective patients**

From October 2017 to September 2018, the average length of stay for all elective patients at Halton General Hospital was 2.6 days, which is lower compared to the England average of 3.9 days.

• The average length of stay for trauma and orthopaedics elective patients at Halton General Hospital was 3.2 days, which is lower compared to the England average of 3.8 days.
• The average length of stay for urology elective patients at Halton General Hospital was 1.4 days, which is lower compared to the England average of 2.5 days.
• The average length of stay for general surgery elective patients at Halton General Hospital was 1.6 days, which is lower compared to the England average of 3.9 days.

**Elective Average Length of Stay - Halton General Hospital**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This Site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>2.6</td>
<td>3.9</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>3.2</td>
<td>3.8</td>
</tr>
<tr>
<td>Urology</td>
<td>1.4</td>
<td>2.5</td>
</tr>
<tr>
<td>General surgery</td>
<td>1.6</td>
<td>3.9</td>
</tr>
</tbody>
</table>

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

**Halton General Hospital - non-elective patients**

No non-elective surgery takes place at Halton General Hospital.

(Source: Hospital Episode Statistics)

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

From December 2017 to November 2018 the trust’s referral to treatment time for admitted pathways for surgery was better than the England average, with the exception of December 2017.
and August 2018 where performance was similar. In the latest period, November 2018, performance was 77.3%, compared to the England average of 65.8%.

(Source: NHS England)

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

Three specialties were above the England average for referral to treatment time 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>86.4%</td>
<td>72.2%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>84.8%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>65.2%</td>
<td>59.3%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for referral to treatment time 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>Urology</td>
<td>67.7%</td>
<td>76.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>42.8%</td>
<td>64.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The musculoskeletal clinical business unit managers had a recovery plan in place to improve referral to treatment times in trauma and orthopaedics. Performance against referral to treatment targets had dropped over time due to the loss of key staff. The posts had now been recruited to and the service had a plan in place to recover their position and improve referral to treatment times in the next six months and were confident this would be achieved. They also had plans to increase use of initiatives such as the ‘hot lists’.

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’s performance was below the England average for five out of eight quarters. From April 2017 there was a rise in the percentage of cancellations with a peak of 27% of 41 cancelled surgeries not treated within 28 days from April to June 2018. In the latest two quarters there has been improvement and in the
latest quarter, October to December 2018, this trust cancelled 63 surgeries. Of the 63 cancellations 3% weren’t treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Warrington and Halton Hospitals NHS Foundation Trust**

Over the two years, the percentage of cancelled operations at the trust followed the trends of the England average but with better performance. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

**Cancelled Operations as a percentage of elective admissions - Warrington and Halton Hospitals NHS Foundation Trust**

(Source: NHS England)

The service had very low levels of cancelled operations. During our inspection we learned that the service dedicated a lot of time and effort into not cancelling appointments unless absolutely necessary. The possibility of cancelled operations was highlighted to senior staff and operations could not be cancelled unless authorised by senior staff. The service had strategies in place such as a social media chat group where they would try and source staff and theatre time. They would also try to source equipment or staff from the Warrington site. The service used a telephone text reminder service to patients to reduce the number of cancellations. The service introduced a theatres cancellation meeting, this group examined the reasons why operations were cancelled and what if anything may have been done to prevent the cancellations.
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

A complaints and concerns policy was in place, this was in date with a date for review and was accessible to staff. The staff we spoke with understood the process and could advise patients and relatives on the process. During the inspection we saw the service had displayed posters and leaflets in patient areas which provided information on how to make a complaint or raise a concern. Leaflets provided details for the trust’s Patient Advice and Liaison Service (PALS) who supported patients and relatives to raise their concerns.

Complaints were managed by a central team who followed the policy regarding acknowledgement of complaints and complaint response times. Complaints were investigated with input from ward managers and relevant staff to gather information pertinent to the concerns raised. We reviewed a sample of complaints and responses and found that these were investigated and responded to appropriately and done so in a timely way.

When complaints remained unresolved, complainants were advised about the opportunity to take their complaints to the Parliamentary and Health Service Ombudsman for review. Between December 2017 and December 2018, no complaints were upheld by the Parliamentary and Health Service Ombudsman for Halton.

We saw that information about complaints, such as the number, the nature of the concerns and any patterns were discussed at patient experience groups and team meetings and minutes were recorded. Trends and recurring themes were examined and learning was implemented and shared. We saw evidence that complaints were shared with staff and learning opportunities were considered. Staff were able to describe some of their complaints and knew the outcomes from them. We saw that there had been changes made following learning from complaints. For example, a complaint was made by a patient, who stated he was not fully advised of the need to stop taking certain medicines before his surgery. As a result, an information leaflet for the pre-operative clinic was devised, this ensured that instructions were written on this leaflet and handed to patients at the pre-operative clinic. This helped patients to understand the instructions and helped to reduce the chance of similar occurrences.

Summary of complaints

From December 2017 to December 2018, there were 17 complaints about surgery at Halton Hospital. The trust took an average of 25 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 60 working days for high graded complaints and 30 working days for moderate and low graded complaints.

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

Number of compliments made to the trust

From January 2018 to December 2018, there was one compliment about surgery at Halton Hospital.

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

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Managers within the surgical clinical business units demonstrated they were skilled and knowledgeable and capable of leading the service effectively. The clinical business unit management teams were enthusiastic and passionate about their units and very eager to continue to develop and keep up the momentum on improvements. Managers appeared genuinely keen to develop the service for the benefit of the staff and service users.

On reviewing quality strategy improvement documents and speaking to managers it appeared that leaders were sighted on the challenges facing their clinical business units and the surgical services as a whole. The managers had undertaken a lot of work in improving safety and performance and had done so without damaging staff morale. Indeed, staff had been central to the improvements seen.

During our inspection and from the staff we spoke we found that staff regularly saw senior divisional and trust managers. Staff were able to name managers and executives and although they were a smaller site they often saw and engaged with managers. Staff stated they had attended talks and witnessed walk arounds from the chief executive and other executive directors. Staff told us they were approachable and visible.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The trust had a set of visions and values which were adopted throughout the service and a mission statement of what it wanted to achieve. This was “Our mission is to be outstanding for our patients, our communities and each other”. During our inspection staff were able to describe the trust objectives around “quality, people and sustainability” and the trust values of ‘working together, excellence, accountable and role model and embracing change’. The vision and values were seen on posters and leaflets and were displayed throughout the department.

The units making up the surgery service had their own clinical strategies and roles within and aligned to the trust strategy. Sustainability and transformation plans were a particular focus and the service involved in the regional transformation projects and system partners ‘One Halton’ and ‘Warrington Together’. Work was underway on working with other healthcare providers to share expertise and develop partnership working and collaboration on various surgical projects.

Patients and staff were consulted about the vision and values and we saw evidence of consultation on changes such as the recent ‘strategy on a page’.

Culture

Managers across the trust were working towards achieving a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
The staff we spoke with during our inspection gave overwhelmingly positive feedback on the culture within the service and of the trust as a whole. Staff told us they were very happy in their jobs, they had a good sense of trust and hospital identity, they felt invested in their role and were proud of the service they provided. Many staff had worked in the trust for many years and many told us they would not consider working anywhere else.

Staff told us there were good opportunities for learning and development and good promotion and career progression prospects. Staff said they were supported to speak out if they felt something was wrong or could be done better and did not fear repercussions if they did speak out.

A freedom to speak up guardian was in place and staff we spoke with were aware of this role and how to contact them. The guardian worked alongside the trust’s senior leadership team to ensure staff had the capability to speak up effectively and were supported appropriately if they had concerns regarding patient care.

Staff achievements were celebrated through awards ceremonies, awarding of certificates and were highlighted in trust literature and on social media.

**Governance**

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There were three clinical business units within the surgery department: specialist surgery, musculoskeletal, and digestive diseases. All units had a clinical director, clinical business manager and lead nurse. The musculoskeletal unit included an allied health professional lead also. This gave a clear structure to provide effective processes and systems of accountability; all senior leaders had clear roles and remit.

There was evidence of good clinical governance procedures and quality measurement processes. These ensured risks were identified and escalated through a series different committees and steering groups to trust and executive level. Messages and issues could be escalated up through the committees to senior manager and executive levels and equally messages could be delivered top down to staff on the ground. During our inspection we saw that messages were being received and acted upon by staff of all grades.

The units functioned effectively and members of staff worked well together. Clinical excellence and best practice was shared across the three units. Staff described sharing of detailed investigations helped to improve best practice. We saw that the units did not operate in isolation and there was good cross unit communication and collaboration.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Each clinical business unit had their own ‘risk register’ which highlighted areas of risk to the running of the service. This register documented the potential risk, the risk score and measured that were in place and ongoing to mitigate the risk. They also had review dates and those designated as responsible for the issue. Risks on the register included staffing, lack of speciality
doctors and potential failures in performance. Risk to the clinical business units were also captured on the trust wide risk register.

The operating theatres had a theatres transformation project group. They measured performance and efficiency in order to identify areas for improvement. Initiatives to improve performance included changes to the safer surgery practices, pre-admission courtesy calls and utilisation initiatives. The team had made some positive improvements and were in the process of implementing further changes which would improve practices in the operating theatres.

The theatres had introduced performance dashboards, these recorded aspects such as late starts, overruns, theatres utilisation and staffing issues such as sickness, vacancies, annual appraisal completion rates and electronic rostering completion. They also analysed the reason why staff left the department in order to understand and reduce staff turnover.

The surgical wards used quality metrics audits to identify performance and areas where they could improve. These were also used in ward accreditation programmes. The service participated in the ‘getting it right first time’ programme which aimed to reduce variations in care across the NHS. The service was working towards understanding and thus improving the variation in surgical care delivered by the trust based on performance metrics and audits.

The service had an annual audit plan, they participated in National and local audits. They undertook audits such as the ‘high impact interventions’ and national early warning score audits to measure their performance and compliance with best practice. These audits were overseen by the trust audit committee.

Financial and activity performance of each of the clinical business units was monitored through the monthly financial resources group. Each clinical business unit presented a dashboard and report each month with the latest activity.

**Information management**

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

Patient records were electronic, these could only be accessed by authorised staff. Staff used individual electronic identity cards to access computer systems and had secure personal log on details also. When a member of staff left a terminal, they removed their ID card which locked the system.

Staff had access to the trust intranet which provided a range of internal and external resource materials to assist staff in their day-to-day tasks. They could access policies, standard operating procedures with ease. Staff also used the system to access training and development information and courses. They used the electronic system to request and retrieve diagnostics, specialist nurse and speciality referrals such as tissue viability and dieticians. There was satisfactory access to terminals and mobile computers to enable staff to access the systems.

Managers on wards and in theatres had good access to various information sources both electronic and manual. These enabled effective management of staffing and human resources, information, equipment and stock. They could also access audit results and performance dashboards to enable them to measure the day-to-day running of their wards and departments and offer areas for improvement.
Engagement

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

The service had various ways of engaging with staff and staff told us felt engaged, informed and consulted.

The ward accreditation scheme enabled staff to feel engaged in seeking improvement and provided a tangible measure of their performance. Staff were consulted on their views, knowledge and ideas. Staff we spoke with appeared to be engaged in the initiatives and wanted to progress their accreditation by improving.

The service had adopted an ‘always events’ initiative, this was a way of engaging with patients, families and friends to gain feedback on ‘events’ they considered to be the most important to them in the course of their receiving care and treatment. The service also opened this up to staff, using the same principles to improve gain ideas on how they could not only improve the patient experience but also improve safety.

The service participated in the Listening into Action scheme, this approach encouraged improvements in team performance and empowerment of teams to make positive changes, thus improving team work and engagement of staff. They also participated in a ‘pulse check’ to gain feedback on how teams were feeling, to understand how well teams were functioning.

“I heart my ODP”, was an initiative on social media to inform the public about the roles of the operating department practitioners (ODP), this was to both promote awareness and also encourage the public to consider this role as a career choice.

The service engaged in co-production initiatives to work with staff on new initiatives and changes. For example, staff in theatres produced new systems and ways of working around the World Health Organisation checklist and safer surgery procedures. Members of the team had identified areas for improvement and come up with their own ideas on how this could be done better. They visited other healthcare providers, consulted the team and came up with new systems which were presented to managers. Staff appeared very engaged and passionate about the work they were doing.

There were daily trust wide safety huddles and morning safety briefings which were started in May 2018, the daily 15 minute huddle brought together representatives from all wards and departments to look at pertinent subjects. They produced a bulletin which was sent to every member of staff every day. This included ‘hot topics’, ‘bright spots’, safety issues, and any ‘HALT moments’. Staff we spoke with felt this was a positive change which has kept them informed and up to date.

The service participated in a trust initiative to engage with patients, service users and members of the public. The ‘What matters to me’ and ‘we asked… you said’, programmes offered a way for the public to express their opinions, wishes and perspectives on the services provided. As a means to show they listened the service responded to issues raised and promoted what they had done by a series of boards around the hospital and surgical wards and areas. These specified the issues raised and what was done as a response to them.

The service also participated in the NHS Staff Survey and Family and Friends Test to gauge the thoughts of staff and the public. Issues specific to the surgery wards and departments and those specific to the Halton site could be uncovered to help managers understand the staff and publics views of the service.
Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The service had processes in place to measure and monitor performance such as audit programmes, performance measurements and dashboards. They used these and other methods to look at areas for improvements.

The service had various co-production groups where staff worked collectively, sometimes with external partners, to ascertain better ways of working. This sometimes involved looking at the way other services were aligned and operated and deciding whether this could work for them. The theatres quality improvement work was a good example of where this had been particularly successful. The service worked on a ‘model operating theatres’ strategy and looked at the safety processes. The service had managed to enhance the safety and had no never events since making the improvements. They had also adopted a ‘lean’ storage and stock practice, which had made dramatic cost cutting improvements and reduced the amount of wasted stock.

The service had introduced ‘hot weeks’ to enable patients who might not have been suitable to be treated at the Halton site to have their surgery completed there. The service ensured additional support and staffing was in place to meet their needs. This improved waiting times for all patients across both sites.
Outpatients services at Warrington and Halton Hospitals NHS Foundation Trust are located across Warrington Hospital, Halton Hospital, Cheshire and Merseyside Treatment Centre with some services provided in a community setting.

At Halton Hospital, the main outpatients department is located on the lower ground floor with clinics also held in the Macmillan Delamere Centre and at the Cheshire and Merseyside Treatment Centre. Some specialities had dedicated outpatient areas including ophthalmology, breast screening, physiotherapy and diabetes clinics.

The main outpatients department consists of 26 consultation rooms at both the Warrington and Halton sites and hosts over 300 medical and surgical clinics per week.

The outpatient department is part of the diagnostics and outpatients clinical business unit and is a key function that supports the effective delivery of service for all clinical business units within the trust.

The Care Quality Commission (CQC) carried out an unannounced inspection between 2 and 4 April 2019. This inspection looked at the outpatient services provided at Halton hospital and included the physiotherapy service, phlebotomy, Macmillan Delamere Centre and Cheshire and Merseyside Treatment Centre.

We spoke with 13 patients, 15 members of staff including senior managers, nurses, student nurses, health care assistants, consultants, middle grade doctors, pharmacists, allied health professionals, pharmacists, domestics and ward clerks.

We observed care and treatment and looked at 12 patient care records. We reviewed comments from staff focus groups and we looked at the service performance data.

(Source: Routine Provider Information Request (RPIR) – AC1. Context acute)

Total number of first and follow up appointments compared to England

The trust had 465,940 first and follow up outpatient appointments from October 2017 to September 2018. The graph below represents how this compares to other trusts.
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 October 2017 to September 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warrington Hospital</td>
<td>264,959</td>
</tr>
<tr>
<td>Warrington and Halton Hospitals NHS Foundation Trust (Unspecified site)</td>
<td>114,663</td>
</tr>
<tr>
<td>Halton General Hospital</td>
<td>111,799</td>
</tr>
<tr>
<td>Halton Surgical Centre</td>
<td>10,948</td>
</tr>
<tr>
<td>Widnes Health Care Resource Centre</td>
<td>3,869</td>
</tr>
<tr>
<td>This Trust</td>
<td>513,592</td>
</tr>
<tr>
<td><strong>England Total</strong></td>
<td><strong>106,751,113</strong></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 October 2017 to September 2018. The percentage of these appointments by type can be found in the chart below:
Number of appointments at Warrington and Halton Hospitals NHS Foundation Trust from October 2017 to September 2018 by site and type of appointment.

Note: appointments assigned to ‘Warrington and Halton Hospitals NHS Foundation Trust’ are where a site was unspecified within the raw data. The total appointments at the trust are assigned to ‘This Trust’.

(Source: Hospital Episode Statistics)
**Is the service safe?**

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

**Mandatory training**

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

Staff told us they were encouraged to complete their mandatory training in a timely way and their manager encouraged them to. We found that the managers monitored the staff’s compliance with mandatory training and that compliance was good.

All staff had access to mandatory training in a range of subjects including health and safety, adult basic life support, infection prevention, equality and diversity, and control and manual handling. Staff told us they could access their records to monitor their own training schedule.

Mandatory training was delivered as a mix of e-learning and face-to-face training which staff said was a good mixture to meet their needs. Staff had recently had face-to-face resuscitation and infection control training within the outpatients department to make the training personal to the staff’s working environment. Some of the gaps in training were due to staff who were on long term sickness.

**Mandatory training completion rates**

The trust set a target of 85% for completion of mandatory training.

The division reported 100% compliance rate between April 2018 to December 2018 for nursing staff.

**Trust level**

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 at trust level for qualified nursing staff in outpatients 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>Counter fraud - No renewal</td>
<td>25</td>
<td>25</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>25</td>
<td>25</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - 3 years</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - No renewal</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>23</td>
<td>23</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control - level 1 - 3 years</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control - level 2 - 1 year</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management awareness - No renewal</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In outpatients the 85% target was met for 15 of the 16 mandatory training modules for which qualified nursing staff were eligible. The fire safety training module was slightly below the target with 82.6% completion rate.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>66</td>
<td>67</td>
<td>98.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>55</td>
<td>56</td>
<td>98.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>55</td>
<td>56</td>
<td>98.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Counter fraud - No renewal</td>
<td>64</td>
<td>67</td>
<td>95.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>64</td>
<td>67</td>
<td>95.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>20</td>
<td>21</td>
<td>95.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - 3 years</td>
<td>19</td>
<td>20</td>
<td>95.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS conflict resolution (England) - 3 years</td>
<td>53</td>
<td>56</td>
<td>94.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>52</td>
<td>56</td>
<td>92.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control - level 2 - 1 year</td>
<td>52</td>
<td>56</td>
<td>92.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>52</td>
<td>56</td>
<td>92.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - No renewal</td>
<td>41</td>
<td>46</td>
<td>89.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 1 - 3 years</td>
<td>39</td>
<td>46</td>
<td>84.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management awareness - No renewal</td>
<td>43</td>
<td>52</td>
<td>82.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - level 2</td>
<td>57</td>
<td>73</td>
<td>78.1%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 85% target was met for 12 of the 15 mandatory training modules for which medical staff were eligible. The resuscitation level 2 training module had the lowest completion rate with 78.1%.
Halton Hospital outpatients department

A breakdown of compliance for mandatory training courses from April 2018 to December 2018 for qualified nursing staff in the outpatients department at Halton Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Counter fraud - No renewal</td>
<td>16</td>
</tr>
<tr>
<td>Dementia awareness - No renewal</td>
<td>16</td>
</tr>
<tr>
<td>Equality, diversity and human rights - 3 years</td>
<td>10</td>
</tr>
<tr>
<td>Falls awareness &amp; post falls pathway - 3 years</td>
<td>13</td>
</tr>
<tr>
<td>Health, safety and welfare - 3 years</td>
<td>10</td>
</tr>
<tr>
<td>Infection prevention and control - level 1 - 3 years</td>
<td>6</td>
</tr>
<tr>
<td>Infection prevention and control - level 2 - 1 year</td>
<td>4</td>
</tr>
<tr>
<td>Medicines management awareness - No renewal</td>
<td>11</td>
</tr>
<tr>
<td>Moving and handling - level 1 - 3 years</td>
<td>9</td>
</tr>
<tr>
<td>Moving and handling - level 2 - 3 years</td>
<td>1</td>
</tr>
<tr>
<td>NHS conflict resolution (England) - 3 years</td>
<td>4</td>
</tr>
<tr>
<td>Resuscitation - level 2</td>
<td>9</td>
</tr>
<tr>
<td>Resuscitation - level 1 - No specified renewal</td>
<td>15</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>9</td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>9</td>
</tr>
</tbody>
</table>

At Halton Hospital outpatients department, the 85% target was met for all of the 16 mandatory training modules for which qualified nursing staff were eligible, with 14 modules achieving 100% completion rate.

The trust report that medical staff in outpatients work across both Warrington and Halton sites to allow for flexibility. This means that the trust is unable to break down the mandatory training data for medical staff for Warrington and Halton Hospitals

**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 85% for completion of safeguarding training.

**Trust level**

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>21</td>
<td>23</td>
<td>91.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>28</td>
<td>31</td>
<td>90.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>5</td>
<td>8</td>
<td>62.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 85% target was met for five of the six safeguarding training modules for which qualified nursing staff were eligible. The safeguarding adults level 2 training module did not meet the trust target with 62.5% completion rate, although this was based on low numbers.

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

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>65</td>
<td>67</td>
<td>97.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>64</td>
<td>67</td>
<td>95.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>63</td>
<td>67</td>
<td>94.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>44</td>
<td>48</td>
<td>91.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>61</td>
<td>67</td>
<td>91.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 3 - 3 years</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>58</td>
<td>67</td>
<td>86.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In outpatients the 85% target was met for all of the seven safeguarding training modules for which medical staff were eligible.
Halton Hospital outpatients department

A breakdown of compliance for safeguarding training courses from April 2018 to December 2018 for qualified nursing staff in the outpatients department at Halton Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 1 &amp; 2 (Basic prevent)</td>
<td>10</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (Prevent awareness)</td>
<td>4</td>
</tr>
<tr>
<td>Safeguarding children - level 2 - 3 years</td>
<td>15</td>
</tr>
<tr>
<td>Safeguarding adults - level 1 - 3 years</td>
<td>13</td>
</tr>
<tr>
<td>Safeguarding children (Version 2) - level 1 - 3 years</td>
<td>20</td>
</tr>
<tr>
<td>Safeguarding adults - level 2 - 3 years</td>
<td>5</td>
</tr>
</tbody>
</table>

At Halton Hospital outpatients department, the 85% target was met for five of the six safeguarding training modules with two modules having 100% completion rate. The safeguarding adults level 2 training module did not meet the trust target with 62.5% completion rate, although this was based on low numbers.

The trust report that medical staff in outpatients work across both Warrington and Halton sites to allow for flexibility. This means that the trust is unable to break down the safeguarding training data for medical staff for Warrington and Halton Hospitals.

Most of the staff had completed the safeguarding training relevant to their role. At the time of the inspection the safeguarding training completion was 94% for safeguarding adults level two.

Staff carrying out clinics with children, or in areas where children may be in attendance had completed level three safeguarding training.

Safeguarding information was displayed on the notice boards within the outpatients department for patients and staff.

A trust-wide safeguarding vulnerable adults and children policy was in place, which covered all aspects of safeguarding including female genital mutilation. The policy was accessible to staff electronically.

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

Staff told us they had access to a trust-wide safeguarding team which included the chief nurse who was the executive lead for safeguarding and a trust wide head of safeguarding who were available for advice during normal working hours. Outside of these hours we were told staff could contact on call managers who could provide advice as required. There were also designated lead doctors and safeguarding lead nurses for both vulnerable adults and children and young persons.

Staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children.

The outpatients department had a clear system and process for the identification and
management of adults and children at risk of abuse (including domestic violence). The service used a system of visual flagging for patient concerns. An alert could be added to the IT system to highlight if patients had previous safeguarding concerns, a learning disability or people living with dementia. There was a free text option to input individualised patient needs as required. We asked two staff to show us how they reviewed or updated alerts for flagged concerns, for example, where an alert of violence and aggression had been placed on a patient record. Although the staff were confident to do this they were unsure how to update the patients risk record. This was raised at the time of the inspection and the staff were aware they could access additional training in relation to the IT system.

Staff and managers told us the department had excellent communication and links with the service’s safeguarding lead. There was accessible support available to staff and managers for advice 24 hours a day, seven days a week.

Clinical, non-clinical and administration staff we spoke with were aware of the types of issues and the process of safeguarding a patient. Five staff we spoke with gave us examples when they would do this. Staff were aware of how to access the trust’s safeguarding guidelines, which were easily accessible. This provided information of how to make referrals when staff had concerns about a child or adults’ safety. Junior staff told us any safeguarding concerns were escalated to the senior nurse and doctor. This was covered within the safeguarding training they undertook. Staff were aware of their legal duty to report cases of female genital mutilation in under 18 year olds and of the assessment for child exploitation.

Clinical and nursing staff in the service were currently trained to level 2 in the safeguarding of vulnerable adults. Recent guidance in the intercollegiate document entitled ‘Adult Safeguarding: Roles and Competencies for Health Care Staff,’ says that “all registered health and social care staff working with adults who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns”, should receive level three training. This guidance is new, and the trust were at the time of inspection deciding on levels of training in the light of this guidance.

Staff had access to individuals who were trained to level three in the safeguarding of children and young people, such as medical staff. The outpatient department had a safeguarding ‘champion’ who could support staff with potential concerns. There was also a children’s ward on the Warrington hospital site which was accessible by telephone for advice at any time of the day or weekends. Following our inspection, we saw that the trust has started to implement level three training for such staff and we saw that training sessions with dates had been arranged. Information regarding the sessions was shared on the trust’s morning safety bulletin.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The trust had an infection prevention and control policy which staff were aware of. All the areas we visited were visibly clean and tidy. We saw cleaning schedules for the daily and weekly cleaning tasks performed. The medical equipment we looked at was clean.

Control measures were in place to prevent the spread of infection. Handwashing facilities, hand gel and protective personal equipment, such as aprons and gloves, were readily available in all the clinic rooms we visited. During the inspection we saw that staff were compliant with best
practice in relation to uniform standards and ‘arms bare below elbows’ guidance. We observed staff, washing their hands, cleaning treatment couches after each patient use in the clinics and using hand sanitising gel in between patient contacts. This was an improvement on the last inspection. We saw patient equipment was labelled and dated with “I am clean” stickers, when cleaned after patient use. Cleaning staff were part of the department and staff took ownership of their own areas.

There was an infection prevention and control team within the trust and infection prevention and control link staff for outpatients. The link staff received further training and support which they could then share with staff in their department. We saw additional study days were made available to these staff members.

Infection prevention and control audits were completed regularly in the department; these covered areas such as uniforms, hand hygiene, sharps and room audits. The results were sent to the managers to produce action plans. Where any audit outcomes fell short of 100% compliance, they were highlighted to managers to ensure the areas of non-compliance were revisited and made clean. A dashboard was available to managers to monitor performance in cleanliness and infection control.

Where appropriate, additional training was undertaken, and random spot checks conducted as follow up actions.

Infection prevention and control was classed as a component of mandatory training for clinical staff. The compliance rate for staff at Halton was 100%, the trust target was 85%.

In the last 12 months the department had recognised the risk of linen pillow cases leaving the outpatients department and moving around the hospital. This has led to the use of disposable pillow cases now being used in outpatients as an infection prevention measure.

**Environment and equipment**

The service had suitable premises and equipment this and looked after them well.

Since the last inspection there had been a programme of refurbishment and improvements had been made to the environment. Some of the work was still in progress but was due for completion two weeks following the inspection, for example the reception area was not yet ready.

The corridors were wide and uncluttered which allowed access for patients in wheelchairs.

Systems were in place to monitor resuscitation equipment. We saw resuscitation equipment was available and checked daily in line with hospital policy. There was a daily checking system in place for a staff member to sign that the trolleys were full and appropriately stocked and equipment was within the manufacturers’ expiry dates. During the inspection we found there was good compliance with the system of monitoring the equipment.

Staff had access to the equipment they needed to care for patients and maintained and used equipment in a way that helped keep people safe. Emergency medicines and fluids were kept in tamper proof cases on the emergency trolleys.

At our previous inspection we found that the chairs where patients attended the phlebotomy clinic for blood tests required improving. We found improvements had been made, since the last inspection. Replacement arm rests had been made and a torn seat replaced.

At the last inspection we found in the main outpatients department, large ophthalmology
machines were stored in the corridor at the back of clinic area C. This had been addressed and the equipment was in a new clinic room.

Systems were in place for the correct disposal of waste materials such as sharps.

**Assessing and responding to patient risk**

Staff completed risk assessments as necessary for patients. They kept clear records and asked for support when necessary.

The patient list was checked by outpatient staff the day before appointments and patient alerts were noted and discussed at the huddle on the day of the appointment. Any additional needs were flagged, and reasonable adjustments considered to meet individual patient needs. Staff told us examples of reasonable adjustments they had made for patients included: providing a quiet waiting area; fast-tracking patients through the department; effective communication with other departments to ensure consistency in patient approach. During the inspection staff had received alerts regarding an ambulance patient coming into the outpatients department and that patients coming into clinic were known asthmatic patients. This enabled staff to be prepared in the event of an emergency.

Staff observed the patients waiting for appointments. Patients could let nursing or reception staff know they felt unwell while they were waiting. Risk assessments were completed for patients who needed extra care during a procedure.

A clear pathway was in place for patients who required admission to the hospital from outpatient clinics. Outpatient staff across departments, were able to describe how to proceed if they were aware of a patient becoming unwell. Equipment was available for nursing staff to take physiological observations and nursing staff would escalate their concerns to a doctor if needed. Resuscitation equipment was available in the department and ready for use. Staff told us they would call for an ambulance in the event of a patient deteriorating.

A system was in place to review patients who missed their appointments or had waited longer than expected to be seen. A policy was in place which outlined the process for contacting and rebooking patients who did not attend their appointments. This ensured patients were not automatically discharged for failing to attend without a clinical review being performed.

We saw evidence of reasonable adjustments to care for specific patient groups, for example prisoners. A risk assessment had been completed which included the need for additional staff. We observed these staff were provided.

Staff within the department had received conflict resolution training so they knew what to do if a patient became aggressive or challenging. Staff we spoke with were able to describe the actions they would take if a patient became aggressive to ensure the safety of patients and other staff.

Emergency pull cords were available in areas where patients were left alone, such as toilets and changing areas.

**Nurse staffing**

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

Nursing staff worked between Halton and Warrington sites, covering and responding to change in
staffing needs on a day-to-day basis as necessary. Rotas were planned according to clinic demands and staff worked flexibly to cover this.

The outpatient manager told us staffing levels were reviewed and pre-planned for each clinic.

A morning safety huddle was held at the beginning of each day. The safety huddle was used to highlight important information and to discuss staffing levels for the day and how any issues were going to managed. We saw that staffing levels were discussed at leadership meetings. Leaders discussed sickness and recruitment within monthly meetings to ensure cover was being arranged appropriately.

The department recognised on their risk register a failure to provide trained paediatric nurses in the main outpatients caused by a lack of paediatric registered nurses employed in main outpatients. This has resulted in a lack of paediatric nursing provision to children attending outpatient appointments. To mitigate the risks the following had been put in place;

- the department had secured funding for a band four associate paediatric practitioner nurse
- all clinics were consultant led and therefore had a named doctor responsible for the child’s care in the department
- consultant paediatricians were all trained in advanced paediatric life-support
- paediatric resuscitation equipment was available in echocardiogram department and Delamere Centre at Halton
- nursing staff were trained in basic life support with paediatric modification covered e-learning
- all staff were reminded to be vigilant and to monitor children in the new play area.

The nursing staff in outpatients told us there were sufficient staff on duty to provide safe and effective care and they did not have concerns over staffing levels. Patients told us they felt staff took time to discuss their care with them appropriately and the staff were available if they needed attention or assistance.

**Planned vs actual**

The trust has reported their nursing staffing numbers from April 2017 to March 2018 and from April to November 2018 in outpatients at Halton Hospital. From March 2017 to April 2018 the trust had 0.4 more WTE in post than had been planned. Actual WTE numbers in post stayed consistent across both periods with the trust increasing the planned WTE for the period April to November 2018.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>GUM Clinic - Genito-urinary medicine</td>
<td>2.4</td>
<td>2.0</td>
</tr>
<tr>
<td>Out-patient department</td>
<td>6.0</td>
<td>6.8</td>
</tr>
<tr>
<td>Total</td>
<td><strong>8.4</strong></td>
<td><strong>8.8</strong></td>
</tr>
</tbody>
</table>

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

**Vacancy rates**
The trust provided us with information on the 2 May 2019 which showed that vacancy rates in outpatients was at 8%, this included nursing and medical staff. This was the second lowest across all the trust’s departments.

**Turnover rates**

From December 2017 to November 2018, the trust reported a turnover rate of 14.7% in outpatients. This is slightly higher than the trust target of 13%.

- Halton Hospital outpatients department: 20.6%. This is higher than the trust target of 13%.

**Sickness rates**

From December 2017 to November 2018, the trust reported a sickness rate of 3.8% in outpatients. This is lower than the trust target of 4.3%.

- Halton Hospital outpatients department: 3.0%. This is lower than the trust target of 4.3%.

**Bank and agency staff usage**

**Halton Hospital**

From December 2017 to November 2018, the trust reported no use of bank or agency staff and no unfilled shifts for qualified nursing staff working in outpatients at Halton Hospital.

During the same period, the trust reported 224 (1.8%) bank hours and no agency hours were filled by nursing assistants in outpatients at Halton Hospital. There were no hours that were left unfilled for this staff group.

An area breakdown is shown below:

<table>
<thead>
<tr>
<th>Ward/Unit</th>
<th>Total hours available</th>
<th>Bank usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>GUM Clinic - Genito-urinary medicine</td>
<td>2,964</td>
<td>24</td>
</tr>
<tr>
<td>Out-patient department</td>
<td>9,478</td>
<td>200</td>
</tr>
<tr>
<td>Total</td>
<td>12,442</td>
<td>224</td>
</tr>
</tbody>
</table>

The outpatients department at Halton had low use of bank and agency staff, however due to staff sickness, we were told usage had recently increased. Where possible they used bank staff who were familiar with outpatients. New staff received an induction and a familiarisation session before they started work. We spoke with a bank staff member told us they had received a detailed induction and had a booklet where their competencies had been signed. This ensured staff could locate information they required and knew who to escalate concerns to.
Medical staffing

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

Planned vs actual

The trust has reported their trust level medical staffing numbers from April 2017 to March 2018 and from April to November 2018 in outpatients. From March 2017 to April 2018 the trust had a fill rate of 84.3% which decreased to 77.1% in the latest period. Both the planned staff WTE and the actual staff WTE had decreased between the periods.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>April 2017 to March 2018</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned Staff WTE</td>
<td>Actual Staff WTE</td>
</tr>
<tr>
<td>Out-patient department</td>
<td>19.8</td>
<td>16.7</td>
</tr>
</tbody>
</table>

Vacancy rates

The trust provided us with information on the 2 May 2019 which showed that vacancy rates in outpatients was at 8%, this included nursing and medical staff. This was the second lowest across all the trust’s departments.

Turnover rates

From December 2017 to November 2018, the trust reported a turnover rate of 21.4% in outpatients at trust level. This is higher than the trust target of 13%.

The trust report that medical staff in outpatients work across both Warrington and Halton sites to allow for flexibility. Where possible, the trust has associated the departments to services/wards but in most cases the trust has allocated the site based on where the majority of work is completed. This means that the trust is unable to break down the turnover data for medical staff at Warrington and Halton Hospitals.

Sickness rates

From December 2017 to November 2018, the trust reported a sickness rate of 0.6% in outpatients at trust level. This is lower than the trust target of 4.3%.

The trust report that medical staff in outpatients work across both Warrington and Halton sites to allow for flexibility. Where possible, the trust has associated the departments to services/wards but in most cases the trust has allocated the site based on where the majority of work is completed. This means that the trust is unable to break down the sickness data for medical staff at Warrington and Halton Hospitals.

Bank and locum staff usage
**Trust level**

From December 2017 to November 2018 the trust reported 4,631 (12.0%) bank hours and 7,610 (19.8%) locum hours were filled by medical staff in outpatients at Warrington Hospital. There were 848 (2.2%) hours that were left unfilled.

<table>
<thead>
<tr>
<th>Site/ward</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Locum Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Warrington Outpatients department</td>
<td>38,527</td>
<td>4,631</td>
<td>12.0%</td>
<td>7,610</td>
</tr>
</tbody>
</table>

The trust reported 19,029 central bank hours worked trust wide which were not able to associate with a specific speciality.

**Halton Hospital**

From December 2017 to November 2018, the trust reported no available hours or bank/locum usage filled by medical staff at Halton Hospital.

**Records**

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

The outpatients department used an electronic medical records system and paper-based records. Patient’s records were available for their appointment. The department recorded the amount of case notes that were missing for appointments.

Patient records were securely stored and were brought from the medical records department as required and returned for storage following the clinic. Records maintained on computer systems were limited to those with authorised access using passwords.

The department carried out monthly audits of the availability and missing medical records. We looked at the audit records for a period of three months. The medical records department recorded 99.5% availability of records in March 2019, 99.8% in February 2019 and 99.8% in January 2019. An escalation process was in place for missing notes and these were reported to the management team for investigation. Minutes confirmed that any themes identified following investigations, were discussed at outpatient steering group meetings.

We reviewed fifteen sets of patient healthcare records. Notes were clear, legible and contemporaneous. Case notes included stickers with patient details and information about next of kin. We saw patient record sheets in preparation for the day’s clinic. Admission front sheets were observed in three patient’s record, with several letters to and from the GP, all filed in date order. These clearly confirmed the patient pathway.

Records we reviewed, included diagnostic results, specialist nurse letters, treatment plans and communication forms. These were dated and signed where appropriate, or recorded as dictated but not signed, for urgent communication purposes.

At the last inspection there were significant national issues with the electronic records system that had caused difficulties with follow up appointment letters. Patients across the country had either received multiple letters for one appointment or not received a letter at all. The trust had
addressed any potential concerns. At the time of this inspection all 15 patients records we reviewed had a follow up appointment recorded.

**Medicines**

The service followed best practice when prescribing, giving, recording and storing medicines. Medicines within the department were stored and monitored appropriately. Systems were in place to maintain security of the doors to medicine rooms, medicines and prescriptions. A record was kept of all medicines and prescriptions issued to patients. Pharmacy staff provided a weekly medicine top up service to the department; expiry dates were checked by the staff. There was no evidence of any medicines past the manufacturers’ expiry date.

Staff within the department issued medicines to patients using a patient group direction. A telephone consultation clinic has been introduced with the colorectal nurses, for a group of suitable patients; allowing improved clinic access for patients. Following a series of questions, the nurse issued medicines to be sent to the patient. If during the telephone consultation the nurse identified possible issues, an appointment would be arranged for the patient to attend the outpatients department.

Patient group direction were used by the colorectal nurses to issue bowel cleansing preparations prior to any clinical procedures. During the inspection the patient group direction was reviewed and complied with the requirements; however, we spoke with a staff member did not have the patient group direction readily available to refer to in the event of a query.

We saw examples where patients had a medicine administered during their appointment. This included details of the name, batch number and expiry date of the medicine, and the doctor’s signature who administered the medicine.

Medicines to treat anaphylaxis were available in the department in the event a patient had a reaction to a medicine administered in the clinic.

Prescriptions pads were securely stored when clinics were not running.

Medicines fridges were kept locked, within a locked room when the room was not in use. Temperatures were monitored, and we saw where action had been taken when the temperature had been outside the normal range. In addition, monitoring of room temperatures had recently been introduced.

Records were kept of prescriptions issued including the serial number, name of patient, hospital number, medicine prescribed and the name of the doctor using the prescription. Nurses held a supply on their person when the clinic was open. Prescriptions were issued mainly during evening clinics or when the medicine was not stocked by the hospital pharmacy.

The pharmacy replenished stocks of medicines against each prescription that was in the cupboard for supplies that had been issued. Any discrepancies in balances would be investigated. We saw where an issue had been investigated, a supply had not been recorded as having been received from the pharmacy. This had been reported to the manager and reported on the incident reporting system, in line with trust policy.

Any known allergies were discussed with patients upon admission to the department and were recorded in the patient’s records. In the records we looked at we found that the allergy status of the patient was clearly recorded.
Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The outpatients department managed patient safety incidents well. Staff had an open culture where safety incidents and concerns raised were valued as being integral to learning and improvement. Staff told us that they were encouraged to report incidents. Reported incidents were reviewed by the matron and discussed in staff meetings. Incidents were discussed at leadership meetings. We saw that incidents were a standing agenda item within the outpatients governance meetings. Lead nurses had time set aside each week to review any incidents.

Incidents were recorded using a nationally used electronic incident reporting system. All staff we interviewed told us that they were trained to use the system and could gain access to the online system.

At Warrington hospital, the senior management team met in a safety huddle every morning to review issues and incidents which had occurred across the trust in the last 24 hours. A summary of the safety huddle was then sent to all teams in Halton and Warrington hospitals.

Staff we spoke with across outpatients were aware of the duty of candour and could describe the principle and how to use it. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

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 February 2018 to January 2019, the trust reported no incidents classified as never events for outpatients.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in outpatients which met the reporting criteria set by NHS England from February 2018 to January 2019. This was treatment delay meeting SI criteria and occurred at Warrington Hospital.

Safety thermometer

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

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 front line is intended to focus attention on patient harms and their elimination.

During the inspection we observed that safety information was being used to improve the service. We were told that falls, the main safety information monitored in outpatients were rare at Halton hospital. In January 2019 there was a record of a no harm patient fall. Following an investigation into a patient fall, further training had been given to staff within the outpatients department. We saw that the noticeboard displayed a protocol of essential care after a patient fall for staff to access. In addition, in response to this a staff member has become a falls champion so they could cascade knowledge to staff.

As part of the refurbishment new, display boards had been delivered and were waiting to be displayed in prominent places within the department. We were told by the manager the information was updated regularly to keep patients and visitors informed about the department’s performance.
Is the service effective?

Evidence-based care and treatment

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

A process was in place to monitor and implement best practice guidance.

Patients were assessed, and treatment was planned and delivered according to evidence based practice such as National Institute for Health and Care Excellence guidelines, standards and best practice.

The trust had a National Institute for Health and Care Excellence coordinator who monitored new guidance and reviewed and directed clinicians to the appropriate area on the National Institute for Health and Care Excellence website to complete a baseline tool. Clinical leads and lead nurses then ascertained the impact on their scope of practice and if changes in the care and treatment processes needed to be implemented. The service aimed to ensure that any changes were implemented within 90 days. The clinical governance group and clinical business unit triumvirate reviewed and actioned any changes. Any deviation or planned departure from the guidance was risk assessed and was agreed through the governance structures and was included on the relevant clinical business unit risk register.

We saw evidence of care pathways and care bundles being followed by staff and staff were aware of best practice and guidance.

Staff and managers described the use of National Institute for Health and Care Excellence guidelines in outpatients and outpatient’s physiotherapy.

We observed guidelines from the National Institute for Health and Care Excellence being used to inform treatment for example for patients with asthma.

We reviewed minutes from staff meetings in the outpatients department where we saw best practice information and shared learning between staff and managers. Staff received clinical updates electronically and policy updates were discussed at staff briefings.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Food and drink was available within the department. Water was available in each department waiting room at ‘hydration stations’. Vending machines were available throughout the main outpatient department.

Arrangements were in place for patients who may be in in department for a long period of time. For example, staff told us they could access ‘snack boxes’ if required for patients who may have to wait for treatment.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it.
Pain relief
Staff assessed and monitored patients regularly to see if they were in pain.

Patients could receive pain relief within the department and could access ongoing pain management services if appropriate. Staff informed us that pain medicine was not generally available for patients in the clinic. We were told that patients would be advised to take oral pain-relieving medicine at home prior to an appointment if necessary, for example during a dressing change. Patients would attend the department with their own pain relief and would administer this themselves if required. The service ran a pain clinic for patients who required referring to for ongoing pain management.

Patient outcomes
Managers carried out audits to monitor and improve patient care.

Leaders described local audits that had been performed to improve patient outcomes.

Audits were carried out within the services that were providing outpatient clinics and action plans were in place to improve service performance.

Following the introduction of a clinical booking database in 2018, staff told us patients’ clinics and their consultants could be prioritised. In addition, the service had a clinic room allocation map to assist in the planning of specialities to improve the service provided for patients.

During our inspection, managers told us that staff had carried out a spinal audit in 2018, which was presented in 2019 and was shown to be clinically positive.

In addition, a ‘grasp trial’ relating to shoulder injuries was in progress at the time of the inspection. The outpatients department also participated in national benchmarks relating to timely access to treatment.

Follow-up to new rate

From October 2017 to September 2018, the follow-up to new rate for Warrington and Halton Hospitals NHS Foundation Trust was higher than the England average.

The follow-up to new rate for Halton General Hospital was higher than the England average.
Competent staff

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

Individual staff had competency based staffing records. We saw records were kept for staff training and competency on using a range of equipment and medical devices. Competency assessments were kept for specific clinical procedures and skills such as cannulation, dressings and medicines management. Preceptorship and training plans were available for newly qualified nurses, nurses joining a new discipline, trainee nurses and associate nurses.

Outpatient staff told us they felt supported by managers, and the organisation, to develop in their roles. Staff described a range of management and clinical development opportunities. The staff team was a mix of experienced staff who had been with the trust for many years and more recently recruited staff.

All new staff were required to undertake an induction, at trust and local level. Qualified nursing staff were supernumerary for the first four weeks and worked alongside a trained nurse.

An induction booklet was available to assist new staff within the department. This ensured staff could locate vital information and knew who to escalate concerns to.

Managers described how they managed poor performance including the development of improvement plans for clinical staff when required.

Appraisal rates

Trust level

The trust target for appraisals was 85% by the end of the financial year. From April 2018 to December 2018, 85.2% of staff within outpatients at the trust received an appraisal.
### Core service

<table>
<thead>
<tr>
<th>Core service</th>
<th>Eligible staff</th>
<th>Completed appraisals</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical (ST&amp;T) staff</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>25</td>
<td>24</td>
<td>96.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>61</td>
<td>53</td>
<td>86.9%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>7</td>
<td>6</td>
<td>85.7%</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>9</td>
<td>7</td>
<td>77.8%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>15</td>
<td>7</td>
<td>46.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>135</strong></td>
<td><strong>115</strong></td>
<td><strong>85.2%</strong></td>
</tr>
</tbody>
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### Halton Hospital

<table>
<thead>
<tr>
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<tr>
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<td>9</td>
<td>8</td>
<td>88.9%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>10</td>
<td>6</td>
<td>60.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
<td><strong>14</strong></td>
<td><strong>73.7%</strong></td>
</tr>
</tbody>
</table>

At the time of our inspection in March 2019, 94.5% of staff had received an annual appraisal. One hundred per cent of medical staff had received an appraisal, 92.3% of nursing staff and 100% of other staff. The trust target for appraisals was 85% by the end of the financial year.

Appraisal assessments were in place for outpatient staff and they directly related to the outpatients department’s business strategy. We saw that managers monitored appraisal rates of their staff. We were told how appraisals were used to discuss progress as well as to identify ongoing development needs. We saw manual records which indicated that most staff within the service had received annual appraisals and that managers were aware when appraisals were due. We saw that managers acknowledged the importance of regular reviews and were aware of the reasons why staff had not had their appraisal, such as long-term sickness or maternity leave.

### Multidisciplinary working

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

A daily hospital huddle of staff from various disciplines was held and attended by a senior representative from the Halton site. Outpatients then replicated the huddle, to ensure planned staffing levels were appropriate to meet the needs of patients. In addition, it allowed identification and forward planning for patients with additional requirements such as children, vulnerable adults or those with complex care needs.

Regular team meetings were held with the staff in the outpatients department to exchange information.

There was good multidisciplinary working in the department as the service used the skills of a range of disciplines in the delivery of care for patients. Referrals could be made to a range of...
trust wide specialist staff such as dietitians, tissue viability nurses, stoma nurses at the hospital and to mental health services provided by another trust. We saw that professionals from different services worked well together to provide quality care for patients.

Staff told us they had positive working relationships between other services for example, physiotherapy, urgent care, fracture clinic and the x-ray department. Some services were based at the Warrington site but were available for advice by telephone or a referral by electronic means.

Physiotherapy service held clinics in the outpatients department for acute injuries and staff could refer to these clinics.

Staff in the department told us they had good working relationship with the local NHS ambulance service. There were regular meetings with the ambulance service to improve the service for patients.

Letters were sent from the outpatients department to patients’ GPs to provide a summary of the consultation.

Seven-day services

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

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests.

Some key services were currently available within the outpatients department. Most of the outpatient appointments were carried out between 8.30am-6.00pm Monday to Friday with some clinics running appointment lists until 8pm and on Saturday mornings. Haematology and breast clinics carried out evening and Saturday clinics.

Additional clinics could be provided at the weekend to meet the demand for certain clinics, for example breast, respiratory and haematology.

Health promotion

The outpatient service provided advice and support for people to improve their lifestyle and to assist them to manage their medical conditions. We saw health promotion leaflets and posters and condition specific advice leaflets available throughout the department. Leaflets in different formats and languages were available.

We observed nursing and medical staff giving patients lifestyle advice on weight loss and smoking to assist them to manage their conditions.

We saw where national health priorities were promoted within outpatients, for example flu vaccinations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards. The trust had a Mental Capacity Act and Deprivation of Liberty Safeguards operational procedure and a Deprivation of
Liberty Safeguards application and management standard operating procedure which were in line with best practice guidance

The trust had a consent policy which had been reviewed and updated regularly and was in keeping with current guidance. Staff knew how to access this electronically. Staff knew how to support patients experiencing mental ill health and when to assess whether a patient lacked the capacity to make decisions about their care. Staff told us they would involve the safeguarding lead if they had concerns regarding a patient’s capacity while attending outpatients.

Staff in outpatients worked on the principle of implied consent but if written consent was needed it was obtained by the consultants in the outpatient clinics. The service used a specific consent form relating to investigations or treatment for a child or young person. We observed verbal consent being obtained before each consultation. Staff were able to describe the steps that should be taken if they had concerns about a patient’s capacity.

Patients we spoke with told us their consultant explained the benefits and risks of treatments and had obtained their written consent where appropriate. We saw records confirming consent procedures were completed accurately.

Staff received mandatory training in dementia and learning disability awareness. Staff were aware of how to support patients with enhanced needs whilst they were in the department.

**Mental Capacity Act and Deprivation of Liberty training completion**

Mandatory training levels were high for both mental capacity and deprivation of Liberty safeguards. The trust reported that from April 2018 to December 2018, Mental Capacity Act (MCA) training was completed by 92.9% of staff in outpatients at Halton Hospital compared to the trust target of 85%. Qualified nursing and health visiting staff had a completion rate of 90.9%.

Over the same period Deprivation of Liberty Safeguards training was completed by 100% of staff in outpatients at Halton Hospital compared to the trust target of 85%.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed all staff treating patients with compassion, dignity and respect. Patients and carers we spoke with told us they had been treated well by staff. We listened to staff being sensitive in their communications with patients and respecting individual needs. We listened to reception staff, nursing and care staff introducing themselves with ‘Hello my name is…’. Patients told us they were given time to ask staff any questions they had.

Due to the refurbishment the reception area was not yet in use, however we observed the staff respecting patient confidentiality as we observed staff speaking to patients without being overheard. At the main entrance we observed patients and family members being welcomed to the department prior to their appointments by the reception staff. Confidential personal information was not discussed for others to hear.

We observed and listened to staff actively promoting patients’ dignity in the outpatients department. For example, we had heard the clinic staff discussing a patient at the morning huddle and had agreed a plan to support the patient. This had included liaison with other relevant clinic staff informed them of the patient’s additional needs; to offer access to a quieter room if the patient required and to make the patient’s journey through the department as timely as possible to ensure a shorter waiting time.

Staff told us they had received dementia friend training which included some information about how people with a disability accessed healthcare services. The improvements to the outpatient environment, had included dementia friendly flooring.

Patients were able to request a chaperone for their appointment if they chose to. The service had a chaperone policy which considered religious and gender identification. We observed chaperone signage in the areas we visited. We observed staff offering chaperones and doctors requesting nurses to chaperone patients.

We observed staff providing emotional and physical assistance as they required. We observed interactions where the staff responded with compassion in a kind and supportive way to patients. We observed a staff member escort a visually impaired patient to their clinic room, as due to the refurbishment, consultants’ names were not on the clinic doors during this inspection. This patient told us they had always received positive care and attention from the ‘excellent, caring staff’.

Feedback from people who were using the service, and those who were close to them was continually positive about the way the outpatient staff treated people. Patients were complimentary about the medical and nursing care.

Work was still in progress to create a quiet room where staff would be able to have confidential conversations, however, the consultation rooms were private, with additional curtains in place for the treatment area to maintain patients’ privacy and dignity.

Friends and Family test respondents from March 2019 were 94% ‘likely’ or ‘extremely likely’ to recommend the outpatient services at Halton hospital.
Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff provided emotional support to patients to minimise their distress and demonstrated an understanding of their condition or their wellbeing. For example, one patient we spoke with said they felt the doctor had listened to them and staff had reassured them this would happen in the future.

Staff told us they looked forward to their quiet room being completed as part of this refurbishment, which was work in progress where they will be able to promote privacy and dignity for any patients who wished to use it.

A chaplaincy service was available for spiritual, religious or pastoral support to those of all faiths and beliefs. There was a multi-faith prayer room on site at the hospital.

Staff had access to psychological therapies to support them in their roles.

Staff told us the team were very supportive of each other especially if they had to deal with difficult emotional situations.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Patient’s relatives were able to accompany them into medical consultations. Patients told us that time was taken during appointments to answer any questions that they or their relatives raised.

Patients understood the next steps in their treatment following their appointments. We spoke with five patients following their appointment and they were aware of their treatment plan. Information provided to patients included a telephone number so patients were able to contact the outpatients department if they required support following their appointment.

Patients told us they felt involved in making decisions about their treatment. From our observations we saw where doctors took time to set out time scales and treatment plans. Appointments were not rushed, and patients told us they were given time to ask questions about their condition and treatment. One patient said; “the staff have been great, they have explained everything along the way. I have felt involved in decisions about my treatment”. We observed patients in the vascular clinic were provided with appropriate information and were given time to ask any questions.

We saw evidence of co-ordinated care in patient case notes. Case notes contained copies of communications between the hospital consultant and the patient’s GP. We were told a system was in place to inform patients ahead of their appointment if the consultant they were seeing had changed.

A process was in place to inform patients on arrival of any delay to their clinic appointment and staff told us that they would contact patients by telephone prior to their arrival to advise of any significant delay. This enabled patients and staff to work together and allowed patients to reschedule their appointments if it was more convenient.
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The hospital website included information for patients and visitors about the outpatients department.

At the last inspection we had noted the décor and furnishings appeared rather run down in the clinic areas at Halton. Since the inspection there had been an extensive programme of refurbishment which was about to be completed. Each clinic had separate waiting areas. These had adequate colourful seating for the number of patients attending the clinics. The corridors and doorways were wide to enable patients in wheelchairs or on trolleys to be able to move through the departments. Disabled access toilets were available and bariatric seating was available in waiting areas.

The Delamere centre had a separate entrance and waiting area to the main outpatients department. This included a comfortable seating area, small tables and chairs, books and magazines.

From the main hospital corridors, the outpatients department was clearly signposted. At the time of the inspection due to the refurbishment programme changes to clinics had confused some patients who had been regular visitors to clinics. We observed staff advising several patients where they needed to be.

General paediatric outpatient clinics were held twice a week in the main outpatients department. At the last inspection we raised concern regarding the lack of child friendly provision. Since the inspection the service had opened a new children’s playroom which was well equipped with toys.

Patients we spoke with told us their test, examinations and follow up appointments were planned in a timely way.

The service posted ‘you said, we did’ posters on notice boards and around the hospital to advise the public how they had reacted to their feedback and ideas and highlighted improvements made.

The service consulted with patient groups, community groups and the foundation trust membership regarding changes or restructuring to services.

The facilities were well located just a short walk from the car park and drop off points. Wheelchairs were available at hospital entrances for patients who required these.

Did not attend rate

A system was in place to monitor and decrease the number of patients that did not attend their appointments.

From October 2017 to April 2018, the ‘did not attend’ rate for Warrington and Halton Hospitals NHS Foundation Trust was higher than the England average and from May 2018 to September 2018, the rate was similar.

From October 2017 to September 2018, the ‘did not attend’ rate for Halton General Hospital was higher than the England average.
The chart below shows the ‘did not attend’ rates over time.

Proportion of patients who did not attend appointment, Warrington and Halton Hospitals NHS Foundation Trust

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

The service took account of patients’ individual needs.

The main department was located on the ground floor and was accessible for patients with a disability. Wheelchairs were made available for patients or relatives with mobility problems.

Systems were in place to notify staff to patients who had enhanced needs. We saw that electronic patient records, recorded and flagged individual patient needs, such as for patients who had a learning disability or were living with dementia. Reception staff told us if they identified a patient with communication needs, these were recorded during the pre-assessment process and an additional alert would be put on the patients file at this stage so staff providing care were aware of any individual needs. Records we looked at confirmed alerts were in place.

Staff told us, and we listened to a safety huddle which was used to highlight any specific patient needs for the day.

Staff could describe the steps they would take to support patients with dementia or a learning disability within the department. The service had clear policies in place supporting patients with mental capacity issues.

In audiology clinics, leaflets and pictorial aids were available to support patients who had a learning disability when they were having investigations and treatment.

The outpatients reception desk had a loop system for patients who wore a hearing aid. There were processes for people who needed translation and interpretation services. Telephone and face-to-face translation services were available to staff; this included access to British Sign Language interpreters. We saw that advice leaflets and information stated that they were available in other languages, the advice was written in the most common languages and scripts
advising how to gain copies. Whilst we did not see any stock copies of leaflets in any of the more common language spoken by members of the local community, we did see that leaflets and information was easy for staff to download and print out to give to patients. Furthermore, patients could access leaflets on the trust internet which they could obtain in different languages. However, we saw that this system was not set up in the same way for patients to obtain copies of leaflets in accessible formats such as easy read and large text.

There was access to mental health support from the local NHS mental health trust if patients required a review and a mental health assessment. All permanent staff had undertaken dementia awareness training and were dementia friends.

Equipment to meet the needs of individual patients was available including, chairs and treatment couches for bariatric patients.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From January 2018 to December 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways has been better the England overall performance. The latest figures for December 2018, showed 90.8% of this group of patients were treated within 18 weeks versus the England average of 87.7%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Warrington and Halton Hospitals NHS Foundation Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty
Nine 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>98.7%</td>
<td>95.2%</td>
</tr>
<tr>
<td>General medicine</td>
<td>95.9%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>95.4%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>95.4%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Other</td>
<td>93.6%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>89.1%</td>
<td>84.4%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>89.1%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>86.5%</td>
<td>85.8%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>82.8%</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

The service monitored the referral to treatment time for the clinics it delivered. We saw that plans for decreasing waiting times were discussed in divisional meetings.

Patients were kept informed about waiting times for each clinic. As part of the refurbishment plans were in place to have new whiteboards in each waiting area to display the current waiting time for each consultant or clinic. We observed nurses telling patients the waiting times and apologising for any delays in appointments.

The service offered some choice of consultants in most specialties and flexibility of appointment times which included evenings and weekends.

Some clinics were held in the evenings and on Saturdays mainly to meet the demands upon service and to provide some flexibility for patients.

Referral to treatment times has been better than the England overall performance for patients and nine specialties were above the England average. Managers were looking at ways to improve this further. They told us they had the flexibility to open extra clinics. They held a weekly meeting that looked at space, staffing, resources and capacity.

A report provided by the clinical business unit on 1 August 2018 showed that urology and ear, nose and throat were not meeting the referral to treatment national indicator. For urology the performance was at 86% against the England average of 92%. For ear, nose and throat in the same period it was approximately 85%. To address performance, managers developed an action plan for both services. Minutes of the performance meeting in January 2019 showed that the trust continued to improve its position and overall waiting list size and was on track to improve.

Three 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>General surgery</td>
<td>88.0%</td>
<td>88.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>81.8%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>68.3%</td>
<td>86.0%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From January 2018 to December 2018 the trust’s referral to treatment time (RTT) for incomplete
pathways has been better than the England overall performance. The latest figures for December 2018, showed 92.3% of this group of patients were treated within 18 weeks versus the England average of 86.2%.

**Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Warrington and Halton Hospitals NHS Foundation Trust.**

(Source: NHS England)

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

Thirteen specialties were 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>Cardiothoracic surgery</td>
<td>100.0%</td>
<td>84.1%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>99.5%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>97.7%</td>
<td>89.4%</td>
</tr>
<tr>
<td>General medicine</td>
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</tr>
<tr>
<td>Ophthalmology</td>
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</tr>
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<td>Thoracic medicine</td>
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<td>Other</td>
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</tr>
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<td>Gastroenterology</td>
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</tr>
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<td>Urology</td>
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<td>Ear, nose &amp; throat (ENT)</td>
<td>87.4%</td>
<td>84.5%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>86.9%</td>
<td>81.3%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).
Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing better than 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), Warrington and Halton Hospitals 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)

The trust is performing better than 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.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Warrington and Halton Hospitals NHS Foundation Trust

(Source: NHS England – Cancer Waits)
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing better than 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, Warrington and Halton Hospitals NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The trust’s complaints and concerns policy was accessible to staff on the intranet. Staff were involved in investigating complaints. Staff we spoke with told us that senior staff were usually responsible for responding to complaints but that staff at all levels were involved in the investigation. Patients regularly complained about car parking fees particularly if the clinic was running late.

Patients were provided with information of how to make a complaint about their care and treatment. We saw leaflets on display with contact details of how to make a complaint. In addition, there was a separate leaflet for people to access the patient advice and liaison service (PALS), who supported patients and relatives to raise their concerns.

Complaints were discussed regularly by senior staff. We saw that complaints were a standing agenda item on monthly outpatient governance meetings. The manager had a high visible presence in the outpatients department and a strong commitment to resolving issues locally where possible. Staff told us they attempted to resolve any patients’ verbal concerns at the time they were raised. All staff were aware of how to signpost patients to the hospital’s complaints policy.

The most recent general theme in outpatients was concerns about delays in being seen, extra letters sent out, and if the appointment was cancelled. The service had a monthly team brief, which followed the executive team brief. This included lessons learned, performance and sharing complaints.
Information for complainants included how to take their complaints to the Parliamentary and Health Service Ombudsman for review. Between December 2017 and December 2018, one complaint was upheld by the Parliamentary and Health Service Ombudsman for Halton. The matron met with the complainant and discussed the work the department were doing with digital letters and the complainant was positive with the feedback.

We saw that information about complaints, such as the number, the nature of the concerns and any patterns were discussed at patient experience groups and team meetings and minutes were recorded. Trends and recurring themes were reviewed, any learning was implemented and shared.

We saw evidence that complaints were shared with staff and learning opportunities were considered. Staff were able to describe some of the complaints and knew the outcomes from them. We saw that there had been changes made following learning from complaints. For example, a complaint was made by a patient, regarding the number of letters they had received. As a result, a task and finish group had reviewed letters and improvements had been made to the digital process for sending letters out. This review had helped to reduce patients receiving cancellation letters and additional appointment letters.

**Summary of complaints**

From December 2017 to December 2018, there were 82 complaints about outpatients trust wide (19%). The majority of these related to patient care (50%), appointments (26.8%) or values and behaviours (staff) (12.2%).

From December 2017 to December 2018, there were 15 complaints about outpatients at Halton Hospital two of which were still open as of 19 December 2018. Of the 13 closed complaints, the trust took an average of 21.9 working days to investigate and close them which is in line with their complaints policy. The policy states that complaints should be completed within 60 working days for high graded complaints and 30 working days for moderate and low graded complaints. The vast majority of complaints are moderate and low grade.

The most common themes of complaints at Halton Hospital were about patient care and appointments with five (33.3%) complaints each.

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

**Number of compliments made to the trust**

From January 2018 to December 2018, there were 20 compliments about outpatients at the trust. Two compliments were about Halton Hospital.

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

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

There had been some recent changes to the management of outpatients that had taken place across the department. Managers within the outpatients’ clinical business unit demonstrated they were skilled and knowledgeable and capable of leading the service effectively. On a day-to-day basis the clinical sister led the department with support from the nurse manager and matron. There were regular meetings between clinical leads and business managers. We observed leaders were visible within their departments. Staff told us that leaders were approachable and accessible in person or by phone. The clinical managers had a strong focus on the needs of the patients and the roles staff needed to play in delivering a good service.

The clinical business unit management teams were enthusiastic and passionate about their unit and very eager to continue to develop and continue to improve. Managers appeared genuinely keen to develop the service for the benefit of the staff and patients. Staff were positive about the clinical lead who had been in post for 8 months. Staff described the outpatient matron as being active in response to departmental issues and the team as ‘fantastic and caring’.

On reviewing quality strategy improvement documents and speaking to managers it appeared that leaders were sighted on the challenges facing their clinical business unit and the outpatient services. The managers had undertaken a lot of work in improving safety and performance and had done so without damaging staff morale. Indeed, staff had been central to the improvements seen.

Leaders were supported by the hospital executive team. Staff told us they were approachable and visible.

Staff told us they regularly saw senior divisional and trust managers. Staff were able to name managers and executives and although they were a smaller site they often saw and engaged with managers. Staff told us they had attended talks and witnessed walkarounds from the chief executive and other executive directors.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The trust had a set of visions and values which were adopted throughout the service and a mission statement of what it wanted to achieve. This was “Our mission is to be outstanding for our patients, our communities and each other”. The vision promoted a sense of belonging to a wider health care community. During our inspection staff were able to describe the trust objectives around “quality, people and sustainability” and the trust values of ‘working together, excellence, accountable and role model and embracing change’. Staff told us they felt their input had been actively sought in the development of the trust’s vision and values. The vision and values were seen on posters and leaflets and were displayed throughout the department.

Patients and staff were consulted about the vision and values and we saw evidence of
consultation on changes such as the recent strategy.

Plans were in place to continually improve the service. The refurbishment of the department had made staff feel valued and was a positive influence on the department. The outpatients staff rotated across the Warrington hospital site which enabled flexible staffing and capacity and was positive for staff development to expose staff to different clinics.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The staff were positive and proud of their work. Staff told us the culture was open and inclusive. Staff gave positive feedback on the culture both within the service and of the trust. Staff said generally they were supported by managers and felt involved in the development of the service.

Staff told us, “the team have improved communication and team working is good within the department”. In addition, staff said, “We are respectful of the need for patient confidentiality. We are all mindful to not discuss patient diagnoses in public areas”. Senior managers told us they had worked hard to change the culture with the staff, so they could see themselves as a significant part of the whole team.

Staff were provided with learning and development opportunities. An induction booklet was in use to ensure staff were comfortable in outpatients. New starters shadowed more experienced staff until they were confident in their role. Staff were provided with development opportunities, these were identified through the departments they worked in or through the appraisal process.

Many staff had worked in the trust for many years and many told us they would not consider working anywhere else.

A freedom to speak up guardian was in place and staff we spoke with were aware of this role and how to contact them. The guardian worked alongside the trust’s senior leadership team to ensure staff had the capability to speak up effectively and were supported appropriately if they had concerns regarding patient care.

The trust supported the wellbeing of its staff. Staff had access to the occupational health team and could access a wellness service which included physiotherapy, hydrotherapy, library services and education.

Staff achievements were celebrated through awards ceremonies, certificates, badges of the trust values. Two staff told us of their pride in being awarded recognition for how they had managed a patient incident. Achievements were highlighted in trust literature and on social media.

Staff were encouraged to have a flu vaccination to help reduce the spread of flu between staff and patients. The service reported high rates of vaccination take up amongst staff.

Governance

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Governance structures, processes and systems of accountability were clearly set out within the
services division. There was a systematic approach to continually improving the quality of the services and safeguarding high standards of care.

Although a newly developed senior team, both staff and managers were clear on their roles and responsibilities and were able to tell us how information was fed up and down into the operational team. There was evidence of good clinical governance procedures and quality measurement processes in place. Risks were identified and escalated through a series of committees and steering groups.

We saw minutes of departmental meeting where issues such as incidents, waiting times, complaints and risks were discussed. We saw that trust wide issues and messages were cascaded back to local team meetings.

Messages and issues could be escalated up through the committees to senior manager and executive levels and equally messages could be delivered to staff on the ground. During our inspection we saw that messages were being received and acted upon by staff of all levels.

Staff described how sharing of detailed investigations helped them to improve best practice. We saw that the clinical business units did not operate in isolation and performance meeting minutes gave evidence of cross unit communication and collaboration.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Outpatients had systems to identify and manage risk and provided controls and assurances for the risks that were identified. Managers in the department could identify what their local risks were, and they shared these risks with staff and senior managers during meetings.

Each clinical business unit had their own ‘risk register’ which highlighted areas of risk to the running of the service. We saw the outpatients risk register dated the 8 January 2019, identified six minor risks and one moderate risk. This register documented the potential risk, the risk score and measures that were in place and ongoing to mitigate the risk. They also had review dates and those staff designated as responsible for the issue.

Staff articulated the same risks as found on the risk register. The highest risk, which was deemed moderate, was regarding patients not receiving appointment letters. There was no pattern around the risks identified.

Financial and activity performance of each of the clinical business units was monitored through the monthly financial resources group. Each clinical business unit presented a dashboard and report each month with the latest activity.

The service had processes to measure and monitor performance such as audit programmes, performance measurements and dashboards. They used these and other methods to look at areas for improvements.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
Staff had access to accurate information to allow them to do their job. Managers had access to performance information for their departments. Staff had access to the trust intranet which contained electronic copies of policies and procedures. Staff had ease of access to policies and standard operating procedures. Staff also used the system to access training and development information and courses.

The electronic patient record system was used to access previous consultations and GP letters, to request and retrieve diagnostics, specialist nurse and speciality referrals such as tissue viability and dieticians. There was satisfactory access to terminals and mobile computers to enable staff to access the systems.

Patient records were electronic, these could only be accessed by authorised staff. Staff used individual electronic identity cards to access computer systems and had secure personal log on details also. When a member of staff left a terminal, they removed their ID card which locked the system.

Performance data was monitored weekly. Referral to treatment times were monitored weekly by the lead to look at clinics and allow operational team and directors to be responsive in their service.

**Engagement**

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

The service engaged well with staff, the public, patients and local organisations to plan and manage services.

The service participated in an engagement programme widely used in the NHS, this approach encouraged improvements in team performance and empowerment of teams to make positive changes, thus improving team work and engagement of staff. They also participated in a ‘pulse check’ to gain feedback on how teams were feeling, to understand how well teams were functioning.

The service participated in a trust initiative to engage with patients, service users and members of the public. The ‘What matters to me’ and ‘we asked… you said’, programmes offered a way for the public to express their opinions, wishes and perspectives on the services provided. As a means to show they listened the service responded to issues raised and promoted what they had done by a series of boards around the hospital and areas. These specified the issues raised and what was done as a response to them.

The service also participated in the NHS Staff Survey and Family and Friends Test to gauge the thoughts of staff and the public. Issues specific to the outpatients and departments and those specific to the Halton site could be uncovered to help managers understand the staff and publics views of the service.

At the time of this inspection the department did not have an outpatient. Following an event to encourage patient engagement in summer 2017 the department picked up concerns regarding letters and the environment. These had been the themes the managers had been working on. They wanted staff at reception to wear uniforms which had been addressed and televisions which were planned to be installed in April 2019.
Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The service was looking to develop virtual fracture clinics for improving patient access and experience in the management of simple fractures. The predication was that up to 30% of patients would be able to have virtual appointments. We were told by the manager; the programme was in the planning and implementation phase and had not yet started.