Warrington and Halton Hospitals NHS Foundation Trust

Halton General Hospital

Quality Report

Quality report
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Good
Medical care (including older people's care)	Good
Surgery	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Halton General Hospital is one of three locations providing care as part of Warrington and Halton Hospitals NHS Foundation Trust. It provides non-complex, elective surgery and a range of outpatient services. There is a minor injuries unit (open 9am to 10pm every day) which provides a range of minor emergency care services, and the hospital provides x-ray facilities until 8pm. There is a step down ward for patients who have had surgery or emergency medical care but who require some further support before going home. There are chemotherapy services on site and the hospital is home to the Delamere Macmillan Unit, which provides cancer support and advice. The site is also home to a specialist orthopaedic facility the Cheshire and Merseyside NHS Treatment Centre (CMTC).

The CMTC is a standalone operating and clinical facility for orthopaedic surgery services across the trust. Warrington and Halton Hospital NHS Foundation Trust provides services across the towns of Warrington, Runcorn (where Halton General Hospital is based), Widnes and the surrounding areas. It provides access to care for over 313,500 patients.

We carried out an announced inspection of Halton General Hospital as part of our comprehensive inspection of Warrington and Halton NHS Foundation Trust.

Overall we rated Halton General Hospital as Requires Improvement.

We found that services were provided by dedicated, caring staff and patients were treated with dignity and respect. However, we found improvements were needed to ensure that services were safe and well-led.

Our key findings were as follows:

Incidents:

- There was individual feedback to staff members following an incident and then feedback to all staff by email and through the safety briefing. The nurse manager said that some of the older staff didn't like to report incidents but the nurse manager had shown how improvements had been made in the department as a result of reporting incidents. One of the issues was that other departments in the hospital were bringing patients to the Urgent Care Centre (UCC), this was inappropriate and as a result of raising incidents the practice was stopped.
- The trust reported low numbers of surgical site infections (SSI) following surgery. Between April 2015 to April 2016, there had been four incidents of SSI in knee replacement surgery and three incidents of SSI in hip replacement surgery. SSI's were monitored by the orthopaedic department in-line with National Institute for Health and Care Excellence (NICE) guidelines for quality standards for orthopaedic surgical site surveillance. The surveillance information collected during April 15 to March 16 showed there had been 672 hip and knee operations and indicated that the orthopaedic joint replacement infections were minimal and mainly superficial infections. This indicated that care and treatment was being delivered with high regard to infection prevention procedures.
- 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. There was a trust wide policy and Duty of Candour process in place. Staff we spoke with had an awareness of the need to be honest when things go wrong although they could not fully describe the requirements of the regulation. Senior staff understood the principles of the Duty of Candour.

Cleanliness and infection control

- The trust had infection prevention and control policies in place which were accessible to staff.
- The areas we visited were visibly clean and tidy. Patients told us areas were clean and that staff washed their hands which reflected what we saw.

Summary of findings

- There was access to personal protective equipment such as aprons and gloves and we saw staff using this equipment appropriately to prevent the risk of the spread of infection. Decontamination procedures were followed in line with best practice in endoscopy.

Environment and equipment

- Daily morning surgical meetings were held to ensure that all staff had the required equipment for the surgeries planned for that day. We observed in theatres staff checking and setting surgical instruments. The check was verbal and visual between two staff in-line with standards and recommendations for safe practice.

Medicines:

- There were patient group directives (PGD's) available for specific nurses to give patients appropriate pain relief. PGD's allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients. This helps patients to access medicines in a safe and timely manner and PGD's were audited by the department. There was a competency framework for those nurses covered by the PGD. Each nurse had their own prescription pad with a dedicated log of the patient's number, the details of the script and the signature of the nurse prescriber. These logs were checked daily to ensure that the numbers of logs tallied with the number of scripts dispended.
- Staff in some outpatient areas used patient group directions (PGD's) to administer medicine without a doctor, such as eye drops or contrast media. The procedures and staff competencies were inspected and complied with standards.
- There were arrangements in place for managing medicines and medical gases. Nursing staff were able to explain the process for safe administration of medicines and were aware of policies on preparation and administration of controlled drugs as per the Nursing and Midwifery Council Standards for Medicine Management. We saw that there was an up to date policy for the safe storage, recording of, administration and disposal of medicines. This was available for staff on the intranet..

Nurse staffing:

- The Urgent Care Centre (UCC) used the emergency severity index (EMS) as an acuity tool to determine the staffing of the department and they had received additional funding for staffing from the clinical commissioning group.
- Within the Outpatient and Diagnostic department, 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 ahead according to clinic demands and staff worked flexibly to cover this.
- We saw staffing in theatres met the Association for Perioperative Practice (AfPP) safe staffing guidelines. This ensured that there were adequately trained staff to provide safe surgical care to patients. We saw from the surgical procedures we attended that there was appropriate staffing levels for each theatre.

Medical staffing

- A resident medical officer (RMO) was based at Halton Hospital 24 hours a day, seven days a week on a rotational basis.
- There was a doctor present in the UCC department from 8am to 10pm. A consultant from Warrington urgent and emergency care department held a weekly clinic in the department.
- There were four GP's who worked in the department. Three of the doctors did one day each and the other doctor worked for four days. The doctors worked from 8am to 10pm. They covered for each other during holiday periods and so there was little use of locum cover

Summary of findings

- On-call senior medical support was available outside of core working hours. Nursing and medical staff confirmed that they were able to access senior medical support if required.

Leadership and Management

- The senior team, in the majority of core services, were visible and accessible and well known to the staff.
- The urgent and emergency care department had undergone a change in leadership early in 2016 with the clinical business unit (CBU) model brought in. The trust had used assessment centres and other management tools to identify leaders in the potential applicants for the clinical and nurse leads for the CBU. The CBU had a clinical lead who was a consultant anaesthetist, a lead nurse and a manager. Both of the clinical staff had come from outside of the department. Since the implementation of the CBU, performance in the department had shown marked and ongoing improvements in safety and performance. This was due to the leadership in the department which was robust and the senior staff led by example.

Access and Flow

- The urgent care centre, saw between 2,500 and 3,000 patients every month, these numbers had more than doubled since the reconfiguration from a walk in centre to an urgent care centre.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the urgent and emergency care centre. In the period from March 2016 to December 2016 the department had consistently achieved over 99%.
- Between October 2015 and November 2016, the average length of stay for surgical elective patients was better at the trust at 2.7 days, compared to 3.3 days for the England average.
- Halton hospital had a shorter length of stay across both elective and non-elective admissions than both the trust and the England average.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards:

- Data showed that of December 2016, 67% of medical staff and 78% of nursing staff had completed their Mental Capacity Act (MCA) training. Staff we spoke with understood the legal requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) in order to protect patients appropriately.
- The service accepted children and young people less than 16 years of age and were able to prescribe emergency contraception. Staff were aware of Gillick competencies and Fraser guidelines. They also said that they would raise a safeguarding referral if appropriate.

We saw several areas of outstanding practice including:

- The public engagement work at the urgent care centre was innovative using the local rugby league clubs to promote the appropriate use of services on their website with You Tube videos.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

In Medicine:

- The trust must ensure that staff receive training on the Mental Capacity Act (2005) and that staff work in accordance with The Act.

Summary of findings

In Surgery

- The trust must take action to provide and maintain an assurance system that World Health Organization (WHO) checklists are completed appropriately as to the standard operating procedure.
- The trust must take action to provide and maintain an assurance system that all anaesthetic machines are checked in line with trust policy.
- The trust should take action to provide and maintain an assurance system that all stocks are within their expiration date.
- The trust should take action to improve the number of suitably qualified staff in advanced life support in recovery.

Outpatients & Diagnostic Imaging:

- The trust must take action to ensure that all safety and quality assurance checks are completed and documented for all radiology equipment, in accordance with Ionising Radiations Regulations 1999.
- The trust must take action to ensure equipment is safely maintained at all times, with repairs completed in a timely way.
- The trust must ensure all appropriate infection control measures, including environmental cleaning, are observed in all diagnostic and treatment areas, with consistent records

In addition the trust should:

In Emergency Department:

- Flagging of patients with a learning disability or those who require special adjustments for their treatment.
- Provide a waiting area for children and young people that is separate to the main waiting room.
- A registered children's nurse available on every shift at the centre.
- Ensure the closure of the low scoring risks on the risk register.

In Medicine:

- The trust should ensure that the required processes and procedures are in place to safely deliver treatment on the planned investigation unit.
- The trust should ensure that staff on the planned investigation unit, receive appropriate training and work within their competence level.
- The trust should ensure that mandatory training and appraisal levels improve.
- The trust should ensure that governance systems are operated effectively at clinical business unit and divisional level.
- The trust should ensure that risk registers are complete and are reviewed regularly with evidence of the outcome of review.
- The trust should ensure it seeks feedback on medical services at the hospital from patients and the public.

In Surgery:

- The trust should take action to improve staffing levels across wards and theatres.
- Although mandatory training performance has improved since the last inspection. The trust should take action to improve their mandatory and clinical skills performance across all core areas.

Summary of findings

In Outpatients and Diagnostic Imaging:

- The trust should ensure all patient case note records are maintained in a complete and chronological order, with accurate details of follow up for patients who did not attend appointments.
- The trust should ensure patients receive sufficient, clear and appropriate information regarding their hospital appointment. This should include adequate directions to clinic locations and relevant written information about treatment plans where this is indicated.
- The trust should ensure departmental risk registers are clearly identified and recorded, with implementation and monitoring of associated action plans
- The trust should ensure directorate communications are in place to provide staff with appropriate support and inform staff regarding departmental arrangements
- The trust should consider actions to improve child-friendly aspects of waiting room environments in outpatient departments.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	We rated urgent care services as good because: The urgent care centre had processes in place to reduce the risk of harm to patients. There was learning from incidents and staff had been trained to appropriate safe-guarding levels. Staff worked to guidance from the National Institute of health and Care Excellence (NICE) and compliance was audited. There was multi-disciplinary working and staff were competent. The department was meeting the Department of Health target for the four hour wait. There was strong leadership and there were governance structures in place that supported the work of the department. Staff were caring and there was good feedback from patients about the work of the department.
Medical care (including older people's care)	Good 	At our last inspection in January 2015 we rated medical services as good. We have maintained the overall rating following this inspection because: There were systems in place to ensure risks to patients were minimised. Staff completed risk assessments and records were completed fully and accurately. The environment was visibly clean and staff followed infection prevention and control best practice including strict decontamination procedures in endoscopy. Nursing staffing and medical cover was generally adequate to meet the needs of patients although there were times when nursing staffing fell below the expected level. Medicines were stored appropriately and checks were carried out regularly on essential emergency equipment. However: There was open access to clinic areas where clinical supplies and medical records were stored. On PIU, trolleys were stored unsupervised in the bay areas with clinical supplies such as needles, cannulas and sterile water for injection. Basic life support training for the acute care division was below the trust target. Safeguarding rates for medical staff were also below the trust target.

Summary of findings

Surgery

Good

At the previous inspection in January 2015, we rated this service as good. Following this inspection we have maintained the overall rating because:
We found there was a good culture of incident reporting in order to learn and share good practice.
Mandatory training compliance across the division had improved following the last inspection and although training in all areas was not above the trust target, improvements were evident.
All floor areas and bed spaces on the surgical wards we visited appeared visibly clean. We saw cleaning schedules were signed and dated to show that areas were clean.
We saw that patient records were structured, legible, complete and up to date and contained risk assessments and care plans that were individualised to the patient's needs.
Staff could identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing or medical emergencies.
Pain scores were regularly recorded, and patients informed us that they were offered appropriate pain relief. The trust's referral to treatment time (RTT) for the percentage of patients seen within 18 weeks was 76.9%, which was better than the England average of 71.5%.
However:
We found that the anaesthetic machines were not always being checked in accordance with the Association of Anaesthetists for Great Britain and Ireland (AAGBI). Daily checks of anaesthetic machines should be recorded daily. This was highlighted to the theatre manager immediately to ensure compliance.
We saw on two occasions that the World Health Organization (WHO) checklist in surgery was not followed fully.
We observed that in one surgical procedure, no formal introductions of the team were completed in the 'time out' section of the checklist.
In another surgical procedure, the anaesthetist was not present for the identification check at the 'sign in' section of the checklist. The WHO checklist is designed to eliminate the occurrence of surgical errors when followed correctly and requires all staff to take part. Since March 2016 there had been three never events relating to surgical procedures at the

Summary of findings

Halton site. Two of these never events occurred in March 2017. 'Never Events' are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented by healthcare providers.
In recovery, we saw that national guidance was not being adhered to ensure there were enough suitably qualified recovery nurses on shift with advanced life support training. Although there were formal audits completed, that included infection control, we saw no evidence that managers had a formal system or process of oversight, that ensured the cleanliness of equipment, and system checks were maintained. However, during the unannounced inspection we saw that the service managers had reacted quickly to our concerns, and new systems and processes implemented with management oversight to ensure compliance with standards and policy.

Outpatients and diagnostic imaging

Requires improvement

We have rated the service Requires Improvement because:
The service monitored referral to treatment times continually. Times were consistently better than the England average, except for urology, ophthalmology and paediatric orthopaedics. Waiting times for referral and treatment for cancer were better than the England average.
The service audited practice well to maintain standards. Radiography staff had received an award for a research paper from the UK Research Council.
Staff were caring and showed understanding in communicating with patients. Administrative, nursing and medical staff took care to show their patients respect and protect their dignity. Patients consistently gave positive feedback about staff.

Halton General Hospital

Detailed findings

Services we looked at
Surgery, Urgent and Emergency Care

Detailed findings

Contents

Background to Halton General Hospital

Halton General Hospital is one of three locations providing care as part of Warrington and Halton Hospitals NHS Foundation Trust. It provides non-complex, elective surgery and a range of outpatient services. There is an urgent care unit (open 9am to 10pm every day) which provides a range of minor emergency care services, and the hospital provides x-ray facilities until 8pm. There is a step down ward for patients who have had surgery or emergency medical care but who require some further support before going home. There are chemotherapy services on site and the hospital is home, to the Delamere Macmillan Unit, which provides cancer support and advice.

The site is also home to a specialist orthopaedic facility – the Cheshire and Merseyside NHS Treatment Centre (CMTC). The CMTC is a standalone operating and clinical facility for orthopaedic surgery services across the trust. Warrington and Halton Hospital NHS Foundation Trust provides services across the towns of Warrington, Runcorn (where Halton General Hospital is based), Widnes and the surrounding areas. The trust provides access to care for over 500,000 patients.

Our inspection team

Our inspection team was led by:

Chair: Bill Cunliff, Consultant colorectal surgeon with 6 years' experience as a medical director

Head of Hospital Inspection (lead): Ann Ford, Care Quality Commission

The team included two CQC Inspection Managers, 12 CQC inspectors and a variety of specialists including Junior doctor, NHS Consultant, Emergency Department Doctor and Nurse, Consultant physician, Clinical Nurse Specialist: Infection Prevention & Control, Surgeon, Lead Specialist Nurse, a Head of Safeguarding, a Senior Governance and Risk Manager, Allied Health Professional, Senior Nurse Practitioner, Clinical Governance lead, Emergency Department nurse specialist and consultant, Specialist Occupational Therapist .

We had four Experts by Experience on the team and held a listening event on 22 February 2016 which was attended by a number of local people who had experienced the services at the trust.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following core services at the Halton General Hospital:

- Emergency Department
- Surgery
- Medical services [Including the care of older people]
- Outpatients and Diagnostic Imaging Services

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We received feedback through focus groups. We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Warrington and Halton NHS Foundation Trust.

Facts and data about Halton General Hospital

Halton General Hospital is one of three locations providing care as part of Warrington and Halton NHS Foundation Trust. In total, the trust has 591 beds. Between January 2016 and January 2017 there were 500,000 individual patient appointments, procedures, stays, and 109,000 emergency department attendances. Warrington and Halton Hospital NHS Foundation Trust provides services across the towns of Warrington, Runcorn (where Halton General Hospital is based), Widnes and the surrounding areas. It provides access to care for over 500,000 patients. The trust employs 4,200 members of staff. The total revenue for the trust was £212.7 million while the full cost was £215.6 million. This meant the trust had a deficit of £2.9 million.

The health of people across Warrington and Halton varies, but outcomes for people tend to be worse than the national average, particularly in the Halton area. Life expectancy for men and women in both areas is worse than the national average. There is also a higher number of hospital stays due to self-harm and alcohol related harm in both areas, compared to the national average.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Requires improvement	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Urgent and emergency services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The urgent care centre was open 365 days per year from 7am untill 10pm and saw adults and children and young people. It was part of the urgent and emergency care department based at Warrington and was commissioned by a local clinical commissioning group. It was previously a walk in centre but had been recommissioned as an urgent care centre.

In the period April 2016 to February 2017, 25,793 patients had attended the department, of these 17,990 were adults and 7,803 were children and young people aged 16 years or under. The numbers of people attending had more than doubled since the change from a walk in centre to an urgent care centre.

During our inspection we spoke with the nurse manager, two band seven nurses, a band six nurse, a student nurse a doctor and a student doctor. We looked at three patient records and three discharge letters.

The urgent care centre was last inspected in January 2015 as a walk in centre and we rated it as good in all domains.

Summary of findings

We rated this service as good because:

- Services were in place to reduce the risk of harm to patients including incident reporting, infection control and audit and checking of equipment.
- Staff were trained to the appropriate levels for the safeguarding of vulnerable adults and children and young people.
- The department were using guidance from the National Institute of Health and Care Excellence (NICE) and other organisations for their clinical care pathways. Compliance with guidance was audited and recorded.
- There was effective multi-disciplinary team working and staff were assessed as competent. There was a culture of staff and service development.
- The department were achieving the standard for emergency departments so that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the urgent and emergency care centre.
- Governance structures were in place and risks were managed in the department. This had improved since the management restructure in April 2016.
- There was strong leadership in the department and staff were mutually supportive of each other, there was good team working.

Urgent and emergency services

- Staff were caring to patients and their relatives and privacy and dignity were maintained at all times.

However

- There was not always a registered children's nurse on each shift.

Are urgent and emergency services safe?

Good

We rated safe as good because:

- Systems were in place to reduce the risk of harm to patients including incident reporting, infection control and appropriate audit and checking of equipment.
- There was an acuity tool for the nursing establishment and all nursing shifts were covered in January and February 2017.There was little use of agency staff and this was mainly to cover staff training and to provide holiday cover.
- There were safe-guarding procedures in place and all staff had received the appropriate training for vulnerable adults and children and young people.
- There was recognised triage system in place and deteriorating patients were identified using an early warning score tool. Deteriorating patients were transferred to the main urgent and emergency care department at Warrington if necessary.

However:

- There was not always a registered children's nurse on each shift.

Incidents

- The trust had an electronic system for the recording of incidents. In the reporting period 1 January 2016 and 31 December 2016, the urgent care centre (UCC) recorded 70 incidents; these incidents were classified as no harm or minor harm.
- There was individual feedback to staff members following an incident and then feedback to all staff by email and through the safety briefing. The nurse manager said that some of the older staff didn't like to report incidents but the nurse manager had shown how improvements had been made in the department as a result of reporting incidents. One of the issues was that other departments in the hospital were bringing patients to the UCC, this was inappropriate and as a result of raising incidents the practice was stopped. The culture of incident reporting was now improved.

- There were other examples of actions being taken in the department following incidents being reported including a verbal assault from a patient which resulted in a review of security in the department.
- We observed that duty of candour was being applied in the department; this was demonstrated through incident investigations. Staff explained to us what duty of candour meant to them and gave us examples of when it had been applied.

Cleanliness, infection control and hygiene

- All areas of the department were visibly clean and tidy, personal protective equipment (PPE) was plentiful and hand gel was available in all areas of the department. We saw that staff used the PPE appropriately.
- The department undertook health care acquired infection monitoring for MRSA, meticillin-sensitive staphylococcus aureus (MSSA), clostridium difficile (c.diff), catheter associated urinary tract infections and wound infections. There had been no infections in the previous 12 months.
- There were weekly audits of hand hygiene, staff uniforms and appearance and daily cleaning schedules. We saw cleaning rotas for rooms and equipment had been completed and that the cleaning and environment audit score was 100% in January 2017 and 99% in February 2017. Hand hygiene audits had scored 100% in the months January 2017, February 2017 and March 2017. Uniform audits had also scored 100% in the same time period. There were also sharps management audits every week which had scored 100% every week in February 2017.
- The outcomes of all audits on infection control and hygiene were fed back to the matron at Warrington. The department had disposable curtains for privacy and dignity, all the curtains we checked were in date including those in the paediatric section.
- The taps were run daily by the housekeeping staff to reduce the risk of legionella infection.
- Patients we spoke with said that they though the UCC was very clean.
- The housekeeping staff had usually finished cleaning before the department opened but they could be bleeped if needed. The porters could also attend to deep clean if required.
- There was a schedule for cleaning toys in the paediatric department, this was weekly but staff said that they would be cleaned more often if necessary.

Environment and equipment

- The department was visibly clean and tidy and there were toilets and baby changing facilities for patients. There was a pleasant waiting room with a reception area with vending machines. This area led into the two triage cubicles which were clean and well-organised. There was a plaster room and an eye room with a slit lamp for the treatment of patients with minor eye conditions.
- The audits for the cleaning of equipment had scored 100% in the period January 2017 to March 2017.
- We looked at a variety of equipment including a sphygmomanometer for checking blood pressure and an electrocardiogram machine (ECG). Both machines had an “I am clean” sticker and had a portable appliance testing sticker which was in date. We also checked ophthalmoscopes and auroscopes; these were also clean with appropriate portable testing stickers on them which were in date.
- Staff said that they checked equipment every morning and that there were full checks every month. During the inspection we checked the resuscitation trolley, it was well stocked, all equipment was in date and all medicines were in date. One of the drawers contained paediatric resuscitation equipment which included interosseous needles, all the equipment was appropriate and in date. There were laminated lists of the contents of the trolleys and standard operating procedures for the procurement and replacement of equipment and medicines. The trolleys also contained procedures for medicines, cleaning procedures, algorithms and early warning score charts.
- In one of the treatment rooms there was a backpack which contained paediatric resuscitation equipment, the check list had been completed and was up to date.

- There were checks every three months on the safety of kick stools, we saw that in December 2016 all the kicks tools were checked.

Medicines

- There were patient group directives (PGD's) available for specific nurses to give patients appropriate pain relief. PGD's allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients. This helps patients to access medicines in a safe and timely manner and PGD's were audited by the department. There was a competency framework for those nurses covered by the PGD. Each nurse had her own prescription pad with a dedicated log of the patient's number, the details of the script and the signature of the nurse prescriber. These logs were checked daily to ensure that the numbers of logs tallied with the number of scripts dispended. Prescription notepads for the doctors were stored securely.
- Fridge temperatures were monitored by the medicines management department. Medicines we checked in the fridges were in date and the daily minimum and maximum temperatures were checked and recorded.
- There was a double locked cupboard for the storage of controlled drugs. We checked these and all were in date, the numbers of drugs were correct and there were the two signatures in the register as required by the trust policy. The medicines management team checked the controlled drugs at the beginning and the end of the day. There had been an audit of the controlled drugs used in the department; staff received individual feedback on the findings of the audit.
- We checked a random sample of medicines in the department, there was a broad range of analgesia and all the medicines we checked were in date. We did observe that some open bottles were not dated and we raised this with the nurse manager, this was addressed before we left the site.
- One of the medicines management team undertook observations of staff administering medicines to patients to update their competencies for medicines management; these competencies were signed off by a senior member of staff.

Records

- Patient records were electronic, staff told us that the systems were well bedded in and they were confident to use them. The records were accessed by an individual smart card and so were automatically assigned to the clinician who was in charge of their care. They were automatically timed and dated. We looked at four sets of patient records all had clear management plans for patients. Records were clear and were signed and dated.
- An emergency nurse practitioner had completed an audit of 150 nursing records of the emergency nurse practitioners and the nurse clinicians. They used the 12 standards of record keeping from the Royal College of Physicians. The average score overall was 83% the lowest scoring area was recording of safeguarding (39% of number of records 64) though other areas scored more highly-the recording of comorbidities (97%), recording of allergies (94%), a clear management plan(96%) and a working diagnosis recorded (95%). There was feedback to the nurses as a whole and individual feedback. Action plans were put in place if necessary
- All patients had an electronic letter sent to the GP following discharge. During the inspection we selected three patients who had attended the UCC on the previous day. All the letters were complete and were dated and timed and were sent out the day that the patients received treatment. We saw that one patient should have attended for diagnostic imaging but had failed to do so; this was included in the letter.

Safeguarding

- There was a trust safeguarding policy and female genital mutilation was part of this trust policy. There were specialist nurses for adult and paediatric safe-guarding in the trust and link nurses in the department.
- All staff had been trained to level two for safeguarding of vulnerable adults. All but one staff had been trained to level three for safe-guarding for children and young people. This was because the training had been cancelled; the manager raised an incident about this. One of the new staff had completed a two day child protection course as well as the level three training.

- On the electronic triage form there was a section for child protection assessment; staff thought that this needed to be nearer the top of the form as it could get missed. There was a separate page on the electronic records system for children. If registered as a child the system would generate a non- accidental injury screening tool within the documentation. This was for children under 16 years of age and would appear in the nursing and doctor's records. If there was a safe-guarding concern about a child there was an alert in the electronic record.
- Staff said that were happy to make referrals to the safeguarding team and to social services and would be supported by senior staff if necessary. There were safeguarding flow charts around the department including the procedure out of hours. The nurse manager attended trust safeguarding meetings.
- If there were concerns from harm about a child they would be transferred to the urgent and emergency care centre at Warrington by ambulance for further treatment.

Mandatory training

- At the time of the inspection we saw the training matrix that showed that all nursing staff were compliant in their mandatory training. This included fire safety, infection control, moving and handling, health and safety equality and diversity, mental capacity act and medicines management.
- The doctors in the department received their mandatory training from their employing trust.
- Training lists were circulated every month to identify those staff that were close to the expiry of their mandatory training or who were non-compliant with their mandatory training. Incremental payments to salaries were withheld for those staff that were not compliant in their mandatory training.
- All staff including porters received training in mental health awareness as part of the induction process.

Assessing and responding to patient risk

- The department used a recognised triage system to manage patient flow and assess patient risk. On arrival at the hospital patients were triaged by a nurse or a doctor. The more serious cases were seen by the doctor. All patients aged less than two years of age were seen by the doctor
- The department used an early warning score tool (EWS) that recorded and scored the patients vital signs and staff were then able to identify patients who were deteriorating clinically. The vital signs were recorded in the patient record and there were clear instructions for the escalation of these deteriorating patients. This was compliant with guidance from the National Institute for Health and Social Care Excellence (NICE). Patients were screened on arrival and this determined if an urgent transfer was required to the Warrington urgent and emergency care department. There was a standard operating procedure for ill or injured people who self-presented at the hospital.
- There was a policy called "Managing medical emergencies at the Cheshire and Merseyside treatment centre and Halton." The policy stated that there was a registered medical officer (RMO) on site and a senior nurse who could support emergency situations as necessary.
- Patients requiring an urgent transfer and deteriorating patients could be transferred to the Warrington site by a 999 ambulance call. In the period 1 February 2016 to 28 February 2017 there were six transfers of urgent and deteriorating patients to Warrington urgent and emergency care centre. Patients who were waiting for transfer to the main urgent and emergency care department at Warrington were reviewed regularly according to the EWS scores, they had pressure areas checked and were made comfortable.
- The consultants at the urgent and emergency care centre were always available by phone to speak with the doctor in the department. Doctors said that they usually rang the department a couple of times per day but sometimes they didn't need to ring at all.
- One of the treatment cubicles was used as an observation area for any patient presenting with chest pain, staff had a good view of this area.
- There was not always a nurse in the department who was trained in advanced life support skills (ALS) though 75% of shifts were covered. All the band seven staff were ALS trained.

- There was a safety briefing every day at the UCC, this took place at 9am. We observed that this was very practical and part of the routine of the hospital, the briefing we saw was attended by four advanced nurse practitioners, there was an attendance register, an agenda and minutes were taken. Items discussed included an infection control issue, the security alarm and the mental health triage document.
- There was an escalation plan which was revised in February 2017 and the status of the department was monitored every hour and any breaches in performance targets were noted. There was an action plan flow chart and patients could be redirected to alternative providers or to the urgent and emergency care centre at Warrington if appropriate. The nurse manager was supernumerary to the staffing of the department and could support the department if it was very busy.
- The department had referral rights to the ophthalmology department at Warrington and had some emergency appointments available daily for any unplanned referrals.
- When the department was near to closing time patients in the waiting room were triaged before being deflected to alternative services, this was always done by a senior nurse.
- Two paediatric nurses had left the department and this had created a gap in nursing staff who were registered children's nurses. This meant that there was not always a registered children's nurse on every shift and the nurse manager tried to put an appropriate nurse on the rota when they expected the department to be most busy with children and young people. Recruitment was underway and this was part of the paediatric transformation plan that was ongoing in the department. This was on the risk register for the department.
- All qualified staff working in UCC at Halton are certified with Resuscitation Council Paediatric Immediate Life support. At the time of CQC Inspection there were additionally three staff trained in Advanced Paediatric Life Support with two additional staff planned to attend Advanced Paediatric Life support Course.
- There were no hot drinks allowed in the paediatric department.

Nursing staffing

- The UCC used the emergency severity index (EMS) as an acuity tool to determine the staffing of the department and they had received additional funding for staffing from the clinical commissioning group.
- The department had some gaps in the staffing. There was a manager for the service and there was over establishment of band seven nurses in the department by 1.7 whole time equivalent (wte) members of staff. There was a gap in the establishment of band six nurses, there should have been 10.5 wte in the department and this included the paediatric nurse vacancy. Following recruitment the department will have 7.6 wte by April 2017 and the department is actively recruiting nursing staff. There were just over the establishment for band five nurses and under establishment for health care assistants (band three).
- There was little use of agency nurses, staff covered through overtime. Agency staff were usually used to cover staff training and holidays. All shifts of qualified nurses were covered in January and February 2017
- Staffing was appropriate to the demands on the services, when the department opened at 7am there were two nurses and a health care assistant as demand tended to be low. At times when there was usually more children in the department, the manager would have a registered children's nurse to cover these shifts.

Medical staffing

- There was a doctor present in the department from 8am to 10pm. A consultant from Warrington urgent and emergency care department held a weekly clinic in the department.
- There were four G.P.'s who worked in the department. Three of the doctors did one day each and the other doctor worked for four days. The doctors worked from 8am to 10pm. They covered for each other during holiday periods and so there was little use of locum cover. The doctors had been there for a few years and so medical cover was stable. The doctors were employed by a neighbouring community trust and were on three year contracts.

- During the inspection there was a foundation level one trainee doctor in the department, they were undertaking a community facing placement and the UCC was part of their training. They were spending a total of eight days in the department. They were supernumerary to the department medical staffing and the doctor said that they provided a useful additional pair of hands in the department.

Major incident awareness and training

- There was a major incident policy and we saw that there was a box file in the department containing action cards to support staff in the event of an incident. There was a decontamination tent and we saw that the batteries were checked weekly and there were dry decontamination packs. These were stored in a secure area in the department. In an emergency situation patients could be redirected to the UCC from Warrington urgent and emergency care centre and there were plans in place for transport arrangements.
- Staff, including porters were involved in scenario training, which was provided by the practice education facilitator; this training had identified additional equipment needs. There had also been training provided by the suppliers of the equipment.
- Following an incident of verbal assault a security review was undertaken, the department has received costings for panic alarms and in the meantime the emergency call buttons were being used to summon other staff if necessary.
- The sonography staff in the department could leave the treatment rooms by an alternative exit if necessary.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good because:

- The department used guidance from the National Institute of Health and Care Excellence (NICE) and other organisations for their clinical care pathways. Compliance with guidance was audited and recorded.
- Patient's pain was assessed and recorded on arrival in the department and appropriate pain relief was administered to patients.
- Staff were competent and there was a focus on training and development for all staff.
- There was good multi-disciplinary working with a range of agencies and organisations.
- All staff had completed their appraisal and there was appropriate supervision for staff.

Evidence-based care and treatment

- The department used guidance from the National Institute of Health and Care Excellence (NICE) and other organisations including the British Thoracic Society, the regional trauma network and local specialist hospitals
- New guidance was assigned to relevant consultants and implementation and compliance were audited and monitored. We saw an example of where NICE guidelines had been updated with new guidance and how this had been circulated to staff through the safety briefings and the clinical governance newsletter which was circulated to all staff in the department every month. There were also emails of governance updates and teaching sessions were used to inform staff of changes to guidance.
- There were a range of clinical care pathways that adhered to NICE guidance and guidance from the Royal College of Emergency Medicine (RCEM) and points relevant to this guidance in the pathways were highlighted in the documentation. These pathways included cardiac chest pain, fractured neck of femur, sepsis and stroke. One of the consultants at the Warrington site was responsible for pathways and these were updated at regular intervals.
- Local audits were carried out in a number of areas including infection control, record keeping and medicines management.

Pain relief

- There were specialist nurses for pain management in the trust who supported the staff in the department if necessary.
- Pain scores were assessed on arrival at the department by the triage nurse and recorded on the electronic record system; appropriate analgesia was administered as necessary. This was audited by the department as part of the record keeping audit in October 2016 and scored 92%.
- We saw that pain levels were addressed during triage and that analgesia was administered to the patient. We observed that an appropriate analgesia history was also taken from one patient.
- In answer to the question "do you think the hospital staff did everything they could to help control your pain and "how many minutes after you requested pain relief medication did it take before you got it" the trust scored about the same as the England average.

Nutrition and hydration

- Patients who had been in the department for a long time were offered drinks and a packed lunch if appropriate.
- Water and hot drinks were available in the department.
- There was a café, a restaurant and a shop on the site but these were not open at weekend.

Patient outcomes

- There was an audit programme that included audits from the Royal College of Emergency medicine (RCEM), the Commissioning for Quality and Innovation (CQUINs) scheme and internal audits for the department. The urgent care centre (UCC) participated in the RCEM audits as appropriate.
- Following sub-optimal findings from the RCEM sepsis audit in 2013/14, the sepsis pathway had been redeveloped and the department were introducing sepsis boxes which contained appropriate equipment and medicines to treat patients with sepsis. A competency assessment had been undertaken so that staff could receive training and competency sign off when using the box. A member of staff showed excellent awareness and gave a description of a deteriorating patient and the sepsis six pathway.
- Audits from RCEM in 2014/15 included " assessing for cognitive impairment in older people the audit had mixed results with one measure scoring in the top 25% and one in the bottom 25% with two other measures somewhere in between. Actions had been put in place following the audit.
- There was a RCEM audit of mental health in the emergency department in 2014-2015 which had also shown mixed results. One of the measures was that patients did not have a documented mental health risk assessment, this had been addressed by the department and appropriate patients undertook a mental health risk assessment at triage.
- The department were constantly looking at the development of more pathways and a head injury pathway for adults and children was in development.
- There were link nurses in the department for safeguarding, metal health, intravenous therapy, infection control and health and safety. The senior nurse was trying to develop more link nurses.
- The department had a pathways group with the local public health team looking at self-care for the public.

Competent staff

- There was a nurse clinical practice facilitator (PEF) for the urgent and emergency care department who had been in post for three years as a clinical nurse educator, the role had evolved as staff were becoming more autonomous and were developing their skills.
- The department were working to the Cheshire and Merseyside trauma network levels of competence standards for nurses. It was expected that staff would achieve level one competence within 12 months of starting in the department and level two within 36 months of starting in the department. There were induction workbooks and competency workbooks for new staff which were completed by staff and their supervisors.
- Compliance with appraisals in the department was 100% and appropriate staff received supervision. Revalidation for nurses had been discussed at the safety brief and senior staff, the practice education facilitator and a link nurse were available to support staff.

Urgent and emergency services

- We spoke with a member of the nursing staff who was currently undertaking the nurse prescribing course; they had study leave for the course and good support from medical and nursing colleagues. They were also undertaking a post graduate qualification in clinical examination and diagnostics and had a medical mentor for development.
- The nursing staff had received cannulation training from the specialist nurses and there were plans for a simulation training event for the administration of intravenous antibiotics. Nursing staff had received training so that they could request some diagnostic imaging.
- The doctors who worked at the UCC did not get study leave but this will be addressed when their contracts are renegotiated later this year.
- The foundation level one trainee doctor said that the experience of working in the department was really useful; they had face to face contact with patients and were well supported by the doctor. They did not discharge patients and checked with the doctor and ANP before discharge.
- One of the paediatricians from Warrington had agreed to mentor appropriate staff to further develop the paediatric service available at the UCC.

Multidisciplinary working

- There was good multi-disciplinary working in the department. Patients had access to diagnostic imaging services including ultrasound and these departments accommodated patients as necessary. Referrals could be made to the dietetic department at the hospital and to mental health services provided by another trust.
- The physiotherapy service held clinics in the department twice weekly for acute injuries and staff in the department could refer to these clinics.
- Staff worked with a number of organisations and could refer people to lifestyle and well- being courses including weight management, mental well- being and smoking cessation services.
- Staff in the department said that they had a good working relationship with the North West Ambulance Service. There were regular meetings with the ambulance service, the commissioners of the service and other local providers.
- There was an alcohol liaison nurse who worked for the trust. They were mental health trained and had developed pathways in the trust for the treatment of patients following alcohol and substance misuse. Their role was to help to identify those patients who were at risk from alcohol and substance misuse, to give advice to the patients and to staff, to plan treatment for patients and to provide aftercare for patients. They had a liaison role and had links to mental health services, social care, housing, the voluntary sector and the police.
- The doctor we spoke with at the UCC commended the team work in the department.

Seven-day services

- The service at UCC was seven days a week, 365 days per year from 7am to 10pm. The doctor was available from 8am onwards. The hospital closed at 10pm.
- Diagnostic imaging was available from 8am to 10pm seven days a week. Pharmacy services were available seven days a week 8am to 11pm Monday to Saturday and 9am to 10pm on a Sunday.

Access to information

- There were a number of computers available around the department and the triage was colour coded so that staff always knew how long patients had been waiting.
- Staff needed a smart card to access electronic systems in the department and temporary staff were allocated with a card
- NICE guidance and clinical pathways were available through the trust electronic system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the skills and knowledge to obtain consent from patients and was clear on how they sought mainly verbal consent from patients. We saw that

consent was obtained and recorded on the electronic record. Patient records showed that verbal or written consent had been obtained from patients appropriately.

- Staff understood the legal requirements of the Mental Capacity Act and the training for this was included as part of adult safeguarding training. The trust lead for mental capacity facilitated the nurse assessment training on the assessment of capacity.
- The service accepted children and young people less than 16 years of age and were able to prescribe emergency contraception. Staff were aware of Gillick competencies and Fraser guidelines. They also said that they would raise a safe-guarding referral if appropriate.
- Staff told us how they would use best interest decisions in an urgent situation,
- The police had been involved in training around mental health and mental capacity and had presented real life scenarios to work through; this had been a training session in November 2016.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- Privacy and dignity was maintained at all times.
- Staff were courteous and kind to patients; they introduced themselves by name and told patients what their role was.
- The friends and family test was better than the England average and patients and their carers were complimentary about the service that they received.
- There were clinical nurse specialists who could support patients

Compassionate care

- The urgent and emergency care department friends and family test (the percentage of people who would recommend the department) was better than the England average between March 2016 and November 2016. The trust were performing worse than the England average from December 2015 until February 2016 and in January 2016 scored 76%, this rose to 92% in April 2016.
- Patients we spoke with said that the urgent care centre was welcoming. All were complimentary about the staff and the care that they had received at the Urgent Care Centre (UCC). A patient told us that they were happy with their care and with the friendliness of the staff. Another patient told us that they were happy with the speed and quality
- We saw that staff introduced themselves by name and told patients what their role was in their treatment. We observed that staff were courteous and kind to patients.
- Privacy and dignity were always maintained in the department and we saw that curtains were always used when appropriate
- Teddy bears had been donated to the department from a local charity so that staff could give them out to children attending the department.

Understanding and involvement of patients and those close to them

- Relatives were involved in the decisions made about patient's treatment and staff communicated with patients in calm and measured way.
- Staff were empathetic to patients and their relatives in their discussions about their care and treatment.
- Staff discussed treatment options to patients and their relatives.

Emotional support

- There were clinical nurse specialists in the trust who were available to support patients in areas including alcohol and substance misuse, dementia, palliative care and transplant/organ donation.
- The alcohol specialist nurse was able to refer patients to increased access to psychological therapies (IAPT). These services were for patients who suffered from mild to moderate mental health conditions such as anxiety and depression and included a range of different therapies.

Urgent and emergency services

- The band five nursing competency framework included a number of modules including compassion, communicating delicate information and confidence in their role. Stage five of these competencies was that staff would be able to support and guide others in compassion with individuals, undertake and deal with delicate situations to a high standard and act effectively as the patient's advocate. These competencies were reviewed regularly and should have been achieved after 12 months in post. Achievement of these competencies would enable staff to effectively communicate, support and advocate for patients.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Good

We rated responsive as good because:

- The department was meeting the Department of Health standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the urgent and emergency care centre.
- There were diagnostic imaging and pharmacy services available to support the department.
- There were interpreting services available if necessary.
- Complaints were dealt with in the time limits of the trust complaint policy.
- The department were using the mental health triage tool to identify individuals at risk.

However:

- There was no flagging system for patients with a learning disability or who required additional support.
- There was no separate waiting room for children.

Service planning and delivery to meet the needs of local people

- The urgent care centre opened at 7am and closed at 10pm. The hospital closed at 10pm.
- The unit was previously a walk in centre but had been recommissioned as an urgent care centre; this was to better meet the needs of the population. This was demonstrated by the increase in patients attending the department. The website for the hospital stated what could and couldn't be treated at the hospital. Patients, if appropriate, were deflected to the most appropriate organisation for their care, these included to their own G.P. to the urgent and emergency care centre at Warrington, to the out of hours service or very occasionally to a nearby hospital trust. If patients were referred inappropriately to the hospital by another provider, this was raised as an incident.
- Patients were informed when they arrived at the hospital what the waiting times were for treatment. When patients were triaged we saw that the electronic system indicated with a colour system how long patients had been waiting in the department.
- There was usually one nurse on triage but if the department became busy and additional nurse was put on triage, there were two triage rooms available. There were four treatment cubicles
- Some diagnostic imaging services were available at the UCC. X ray facilities were open from 8am to 10pm seven days a week and were close to the department. There was an ultrasound service located in the department; although there was a running list for the day the sonographers would accommodate patients who needed a scan. This was for conditions such as deep venous thrombosis.
- The department accepted ambulance patients who had low acuity conditions or minor trauma. They used the urgent care centre kite marked guidelines from the North West Ambulance trust. This helped to divert less urgent patients away from the main urgent and emergency care centre at Warrington and the vast majority of these patients returned home following treatment.
- Pathology services were available from 8am to 5pm and after these times, samples and specimens for analysis were sent to the hospital in Warrington, the doctor told us that this could cause a delay of up to two hours.

Urgent and emergency services

- There was a pharmacy on site Monday to Friday 9am to 5pm. There was also an external pharmacy that opened from 8am to 11pm Monday to Saturday and 9am to 10pm on a Sunday.
- There was an eye room with a slit lamp so that the department could see patients with minor eye injuries or infections.
- The department could refer patients to the rapid response team, intermediate care services and district nursing services.
- There was an out of hours service at the hospital that was led by G.P.s, this was by appointment only and was available 6.30pm to 8.00am Monday to Thursday and 6.30 pm to 8am on Monday. This service was not part of the urgent care service (UCC) though the service shared facilities.
- We spoke with three patients at the UCC, one had been before and complained that they waited 40 minutes before their treatment which they considered to be a long time; another patient said that she was pleasantly surprised by the visit.
- There was free parking for patients at the UCC; patients thought that this was a good idea. There was a bus that ran between the two hospital sites that patients could access and staff could book taxis if necessary to take patients to the Warrington site.
- There were signs in the department that indicated to patients the different types of staff working in the department.
- There was a paediatric department which had restricted access. There were two observation rooms and two treatment rooms and a play area for young children. There was no separate waiting room for children and the area was not separated from the adult area.

Meeting people's individual needs

- The staff had undergone training for dementia, there was a nearby residential home for older patients with dementia and cognitive impairment and patients from the home sometimes attended the unit following a fall, this was always with a carer.
- There was a local community of gypsies and travellers. This community usually attended with acute problems and were not always registered with a GP. The department would try to register them with a GP but not all practices would accept them.
- Staff were using the mental health triage tool but had made some adjustments to it following an incident with a patient. The tool highlighted possible issues with alcohol and substance abuse and referrals could be made to community services. There was a folder in the department containing relevant information to signpost patients to appropriate services.
- All staff were booked on mental health first aid training to support them to deliver appropriate care; this included the reception staff from the department to patients with mental health problems.
- Staff could refer patients to mental health services that were provided on site by a nearby mental health trust.
- Staff could refer patients to a voluntary organisation that supported positive mental health and well-being. This included patients who attended frequently with vague symptoms and people who were lonely.
- There was no flagging system for patients with a learning disability or those needing special adjustments. The trust has completed a safeguarding review and this concern was highlighted and the trust has informed CQC that there is work in place to address these issues.
- Staff could access interpreting services if necessary using a two way hand set, the areas has a low black ethnic minority population and most people requiring interpreting services were Eastern European. The department were starting to develop a service for people with hearing difficulties. This followed a complaint at the urgent and emergency care centre at Warrington.
- Chaperones were available if patients requested them and we saw signs to inform patients that this service was available.
- Staff told us about a patient who was a frequent attender who had a learning disability. They were concerned about them and contacted social care, the patients G.P. and raised a safe-guarding concern.

- There were not enough children attending the department for a play specialist but staff were learning distraction techniques.

Access and flow

- The department saw between 2,500 and 3,000 patients every month, these numbers had more than doubled since the reconfiguration from a walk in centre to an urgent care centre.
- Patients were triaged on arrival in the department using a recognised triage tool. An electronic display indicated to staff how long patients had been waiting with different colours on the screen.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the urgent and emergency care centre. In the period from March 2016 to December 2016 the department had consistently achieved over 99%.
- Any breaches that occurred were usually as a result of patients waiting to be transferred to Warrington.
- The target for triage times was 15 minutes or less; in January 2017 the department achieved 72% of patients seen in 15 minutes or less and the average triage time was 13 minutes. In February 2017 achieved 80.6% of patients seen in 15 minutes or less and the average triage time was 11 minutes. In March 2017 79% were seen in 15 minutes or less and the average triage time was 11 minutes. In January 2017 11 patients waited for more than an hour for triage, this was two patients in February 2017 and seven in March 2017.
- The department had designed posters about the top five attendances for different ages of patients and a cost comparison of the venue where they could receive treatment. Patients could see the different costs attributed to each provider.

Learning from complaints and concerns

- The department received about five complaints every year. There was an ongoing complaint at the time of the inspection about the attitude of a member of staff. The department was meeting the trust timescales for the complaint.
- One complaint had been referred to the Parliamentary and Health Ombudsman. This was concerning a missed fracture and the department were waiting to see if the complaint had been upheld. Measures had been put in place reduce the risk of this happening again.
- Staff tried to address complaints face to face or they referred patients to the PALS department. We saw that duty of candour was applied during the complaints process.

Are urgent and emergency services well-led?

Good

We rated well-led as good because:

- Since the implementation of the clinical business unit model, governance at the urgent care centre (UCC) had improved and there were better links with the urgent and emergency care department at Warrington.
- There was strong nursing leadership in the department with support from the urgent and emergency care department at Warrington.
- Staff morale was good and staff were proud to work in the department.
- Public engagement was innovative and the department were working with a range of organisations to promote the work of the department and care in the most appropriate place.

However

- There were some low scoring risks on the risk register that could be closed.

Leadership of service

- The senior managers had the skills, knowledge, experience and integrity that they needed to lead effectively. The new divisional structure was embedded and led by a senior management team and were aware of their current performance and direction of the trust.
- The nurse manager said that the leadership in the department was much improved since the

introduction of the clinical business unit (CBU) for urgent and emergency care in early 2016. They said that before this nurse leadership was poor and that they were not supported. The new nurse lead for the department was providing better supervision and was responsive to any issues raised by the manager of the UCC. They also said that the role of the business manager in the CBU was supportive to their service.

- Ward B1 and the PIU were managed within the acute care division within the specialist medicine business unit (B1) and the diagnostics business unit (PIU). Both of these CBUs were managed under the acute care division. The endoscopy unit was managed by the digestive disease business unit which sat within the Surgery and Women's and Children's Health division. This was a new management structure that had come into effect in April 2016. Services had been allocated to CBU based on a patient pathway rather than the traditional hospital model of medicine and surgery. Each CBU was led by a nurse, doctor and operations manager. Leaders in each CBU were being supported to develop their leadership skills through internal and external courses. Staff spoke positively about the reorganisation of management structures that were more centred on a patients care.
- Theatres and ward-based staff told us they clearly understood the management structures and they received good support from their immediate line managers.
- Many diagnostic staff told us they didn't know the clinical business manager, who had been in post almost 12 months, and felt there was poor connection to the clinical leads for each speciality. There were regular meetings between clinical leads and business managers but we were told that there were no regular diagnostic staff meetings. Information was emailed to each clinical area lead to be shared with staff. The principal radiographer told us there was an open door policy within diagnostic imaging for staff with concerns.

Vision and strategy for this service

- There was a vision for the department which was the strategic work programme; this included five current strategies of work and the progress of these strategies which were mainly about the development of the workforce and improving performance. Appropriate strategies involved partners from outside the organisation.
- The department were working with the clinical commissioning group to further develop their services.
- Staff we spoke with were aware of the vision for the department particularly in improving the performance of the department. The nurse manager said that they didn't want to stand still and wanted to improve the safety and performance of the department but while still maintaining the strong links with the urgent and emergency care department at Warrington.
- Staff were encouraged to develop new skills and competencies to further develop the range of services that the UCC could offer.
- The paediatric urgent and emergency care department had only become part of the main department in the month before the inspection. A transformation plan with an accompanying training needs analysis had been developed and a nurse consultant had been brought in from a neighbouring trust to drive and support the necessary changes in the department.

Governance, risk management and quality measurement

- The urgent and emergency care department had undergone a change in leadership early in 2016 with the clinical business unit (CBU) model brought in. The trust had used assessment centres and other management tools to identify leaders in the potential applicants for the clinical and nurse leads for the CBU. The CBU had a clinical lead who was a consultant anaesthetist, a lead nurse and a manager. Both of the clinical staff had come from outside of the department.
- The nurse manager at Halton attended the departmental governance meetings and the audit meetings every month at Warrington. There was a standard agenda template for the meetings and agenda items included a review of guidance from the National Institute of Health and Care Excellence (NICE), a review of complaints, incident investigations,

action plans for serious untoward incidents and investigation reports. Mortality was also discussed. The nurse manager had not been invited to these meetings before the introduction of the CBU.

- There was a development group of the UCC which had membership from a nearby trust, a nearby urgent care centre, the North West ambulance service and the clinical commissioning group. The group looked at pathway development and networking between the different organisations.
- The department completed a performance dashboard for the clinical commissioning group to inform them about the performance of the department.
- There was a risk register which was reviewed monthly as part of the directorate meetings and appropriate risks were escalated to the corporate risk register. Each risk had a mitigation plan. One of the risks on the register was the lack of a paediatric trained nurse on every shift in the department. There were a number of health and safety risks which could be reviewed and possibly closed as the risk rating was very low.
- There were regular staff meetings in the department, we saw minutes that showed that complaints, were shared with staff, there was a review of incidents and feedback and new protocols and pathways for different conditions.

Culture within the service

- There was an open culture in the department which supported learning from incidents and was focused on patient safety.
- A member of staff told us that there was a good and happy atmosphere in the department with a cohesive team who had similar values. There was a family friendly approach to staff rostering with mutual consideration and respect to all members of the team.
- Staff said that they liked working there and were proud of the work that they did.
- The nurse manager said that previously the staff had felt demoralised and isolated but morale was improved since the introduction of the CBU.
- At the end of all the minutes of the meetings were thanks to staff for all their hard work.
- Managers said that staff didn't always take breaks when they should have done; this was because they didn't like to keep people waiting.
- The trainee doctor in the department described the placement as positive and said that the nurses were very helpful.

Public engagement

- The urgent and emergency care departments at Warrington and Halton were working with players and staff from two local rugby league clubs. The department was promoting awareness of the different urgent care services and when to use these services appropriately. Filming was due to take place for YouTube videos which would be promoted via the social media platforms at one of the rugby clubs.
- Patients we spoke with said that the UCC was highly regarded by local people and that it had a good reputation.
- The nurse manager had been on the local radio several times and staff had manned a stall at a local vintage car rally. This was to promote the services offered at the UCC. There had also been articles in the local free papers to promote self-care for children and young people over the winter period. The department worked with local charities that provided support to the department.

Staff engagement

- The department was very busy and the senior management team had introduced stress risk assessments that were completed on line. If the scores were high there was input from the occupational health department. The risk assessments were mandatory and carried out every year.
- There was a closed Facebook page for the urgent and emergency care department, this was used as a communication hub and was well used. Managers knew how many staff had read messages and staff we spoke with thought it was a great idea and that it worked well.

Innovation, improvement and sustainability

Urgent and emergency services

- The unit had developed from a walk in centre to an urgent care centre, this had addressed the needs of the local population and there was potential to further develop services delivered from the centre.

Medical care (including older people's care)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Good

Information about the service

Medical care at Halton Hospital is provided from one inpatient ward (B1), an endoscopy unit and a planned investigation unit (PIU). There were 7,088 inpatient medical admissions between October 2015 and September 2016. Ward B1 is a 22 bedded intermediate care unit with four side rooms. The ward is staffed and managed by Warrington and Halton Hospitals NHS Trust; however admission to the unit is controlled by the local commissioning group who commission the service. The planned investigation unit has 15 beds for day case treatment and 18 chairs.

At our last inspection in January 2015, we told the trust it must take action to improve medical services in a number of areas. This included ensuring resident medical staffing had the required skills and competencies and improve mandatory training completion.

We visited the hospital as part of our announced inspection between 7 and 10 March 2017. We inspected ward B1, the endoscopy unit and the planned investigation unit. We did not carry out an unannounced inspection at this service.

As part of our inspection, we observed care and treatment and looked at six sets of patient records. We spoke with 11 staff, including nurses, consultants, support workers, managers and allied health professionals. We also spoke with four patients or their relatives who were using the services at the time of our inspection. We looked at information provided by the trust and other relevant information we requested. We received comments from people who contacted us to tell us about their experience at the trust and reviewed performance information.

Medical care (including older people's care)

Summary of findings

We rated this service as good because:

- There were systems in place to ensure risks to patients were minimised. Staff completed risk assessments and records were completed fully and accurately. Nursing staffing and medical cover was generally adequate to meet the needs of patients.
- The environment was visibly clean and staff followed infection prevention and control best practice. Medicines were stored appropriately.
- Care and treatment was delivered in line with national guidance and best practice. There was a lower than expected risk of readmission and patient outcomes were generally good. The trust met the national target for treatment waiting times.
- The endoscopy unit had achieved Joint Advisory Group on Gastro Intestinal Endoscopy (JAG) accreditation.
- Staff were kind, caring and compassionate and they worked well together as a multidisciplinary team. Staff recognised the emotional needs of patients and the importance of involving family members when planning care and treatment.
- Adjustments were made for patients with individual needs such as a learning disability or those living with dementia. Individualised care plans were used for patients living with dementia and carers were encouraged to stay with this patient group.
- Services had been planned to meet the needs of local people in conjunction with other local stakeholders and plans were in place to further develop these services in the future.

However:

- Mandatory training and appraisal rates were below target for some staff groups. Staff on the planned investigation unit had not completed competencies and some staff had undertaken duties they had not been trained to perform.
- The clinical governance structure within the acute care division was not sufficiently embedded into practice. We saw no evidence that risk, risk management and quality measurement was discussed within most clinical business units.
- Not all areas used the NHS friends and family test or other local patient feedback to gather information about the services they provided.

Medical care (including older people's care)

Are medical care services safe?

Good

At our last inspection in January 2015 we rated safe as requires improvement. We rated safe as good at this inspection because:

- There were systems in place to ensure risks to patients were minimised. Staff completed risk assessments and records were completed fully and accurately.
- The environment was visibly clean and staff followed infection prevention and control best practice including strict decontamination procedures in endoscopy.
- Nursing staffing and medical cover was generally adequate to meet the needs of patients although there were times when nursing staffing fell below the expected level.
- Medicines were stored appropriately and checks were carried out regularly on essential emergency equipment.

However:

- Not all staff on the planned investigation unit could access standard operating procedures designed to keep patients safe when undergoing intravenous infusions of medications.
- There was open access to clinic areas where clinical supplies and medical records were stored. On PIU, trolleys were stored unsupervised in the bay areas with clinical supplies such as needles, cannulas and sterile water for injection.
- Basic life support training for the acute care division was below the trust target. Safeguarding rates for medical staff were also below the trust target.

Incidents

- Staff reported incidents using an electronic reporting system. Staff were able to demonstrate how they reported incidents and said they felt confident using the system.
- Between September 2016 and March 2017, there were 5,053 incidents reported within the acute care services division at the trust. Over 98% of these incidents were classified as no or low harm.
- Most staff were able to describe how learning from incidents was shared. One member of staff believed there was a culture of under reporting near misses or incidents with low harm.
- Staff gave examples of incidents they had reported and learning as a result of these incidents. Learning was shared through team briefs, safety huddles and staff meetings.
- There had been no serious incidents at Halton Hospital for medical services during 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive investigation.
- Between January 2016 and December 2016, there were no incidents which were classified as never events for medical services at Halton Hospital care. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- We noted that there had been two incidents of mislabelling samples in endoscopy. We requested the review of the second incident and found that a full review of this incident had not been conducted. The trust told us that expected practice was to conduct a 72 hour review but that the incident had been closed following review by the endoscopy manager. A review using a 72 hour review format was completed following our inspection and shared with us to ensure any additional learning was identified and shared.
- Mortality and morbidity was discussed at monthly mortality and morbidity meetings. Serious cases were shared at the divisional clinical governance meeting.
- 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. There was a trust wide policy and duty of candour process in place. Staff we spoke with had an awareness of the need to be honest when things go wrong although they could not fully describe the requirements of the regulation. Senior staff understood the principles of the duty of candour.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), should be monitored on a monthly basis.
- Ward B1 used the NHS safety thermometer to monitor harm and harm free care and results were displayed on information boards at the entrance to the ward area.
- Data from the safety thermometer showed that there had been 10 new pressure ulcers, no falls with harm and no new catheter urinary tract infections for ward B1 between February 2016 and February 2017.

Cleanliness, infection control and hygiene

- The areas we visited were visibly clean and tidy. Patients told us areas were clean and that staff washed their hands which reflected what we saw.
- Cleaning schedules were in place and used by ward domestic staff. Equipment was cleaned following patient use and labelled with an 'I am clean' label.
- Staff were "bare below the elbow" and washed their hands or cleansed them with hand gel before and after contact with patients or their surroundings.
- There was access to personal protective equipment such as aprons and gloves and we saw staff using this equipment appropriately to prevent the risk of the spread of infection. Decontamination procedures were followed in line with best practice in endoscopy.
- All wards had antibacterial gel dispensers at the entrances and by people's bedside areas. Appropriate signage regarding hand washing for staff and visitors was on display.
- Sharps containers were dated and signed when assembled and temporary closures were in place when sharps containers were not in use.
- Patients with a known infection were nursed in side rooms and signs were placed on the entrance to these rooms to notify staff and visitors of the need to follow extra precautions. Information about infection was shared with staff during ward safety huddles to ensure staff were aware of any additional infection prevention and control precautions.
- There had been no cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia or hospital acquired clostridium difficile infection in medical services during 2016.
- Infection prevention and control training had been completed by 90% of nursing staff and 71% of medical staff.
- Matrons completed monthly infection prevention and control (IPC) reports that included hand hygiene audits, uniform audits and environmental audits which included the endoscopy unit. The reports showed a high level of compliance on these audits. However, we saw no evidence in the reports provided that these had been completed on B1 or the PIU.
- Matron IPC reports were discussed at a monthly infection prevention and control subcommittee. We review the minutes of these meetings and saw that any issues identified in these reports were discussed in this meeting along with the actions being taken to improve compliance where necessary.

Environment and equipment

- The environment in each area we visited was clean, bright and tidy.
- Resuscitation trolleys were available in all areas we visited and were tagged with tamper proof seals. Trust policy set out that a full check of the trolley should be completed monthly, or following use of the trolley and a daily more limited check should be completed whenever the ward or area was open to patients. We

checked the trolleys in all areas we visited and saw that checks had been completed correctly. We also checked the contents of the trolley on the planned investigation unit (PIU) and saw that all stock and medications were within the manufacturers recommended expiry date.

- All equipment we checked including vital observations machines had been tested for electrical safety and was clearly labelled with the date that the next test or service was due.
- Patients told us the environment in the endoscopy unit was calm, clean and relaxing.
- We saw that there was direct access to theatres three and four through open and unsupervised doors on the endoscopy unit. Staff told us there had not been any incidents of patients or the public accessing theatres through these doors. However, there was a risk that access to theatres could be gained by unauthorised people.
- On ward B1 and the PIU, we saw that there was open access to clinic areas where clinical supplies such as sharps, dressings and other sterile items were stored. On PIU, trolleys were stored unsupervised in the bay areas with clinical supplies such as needles, cannulas and sterile water for injection. There was a risk of unauthorised access to these clinical supplies and a risk that these supplies could be tampered with.
- We noted that the dirty utility room on B1 was unlocked and contained chemicals such as chlorine based cleaning solution which was stored in a cupboard that was also unlocked. We highlighted this to staff who immediately took action to lock the chlorine solution away.

Medicines

- Medicines were stored securely and appropriately. Nursing staff carried keys to access controlled drugs at all times. Fridges were locked and temperatures were checked and recorded daily. Guidance was available for staff to use if temperatures fell outside the recommended range.
- Controlled drugs were stored in line with Home Office regulations. Controlled drugs records books were completed correctly including all relevant information and signatures.
- We checked a sample of medicines and found that these were all within date.
- Between September 2016 and March 2017, 398 incidents related to medicines were reported within acute care services. Seventy-one per cent of these incidents were graded as no harm. There had been only one incident were harm to the patient had been graded as moderate or above.
- Medications were prescribed using a paper drug cardex which was stored with the nursing documentation. We reviewed three prescription charts and saw that they were completed appropriately including allergy status and regular medications, one off and as required medicines. The trust was in the process of moving to electronic prescribing of chemotherapy products.
- Staff reported there was a good level of support from the pharmacy team on PIU particularly in relation to chemotherapy products.
- The trust reported that 90% of nursing staff and 77% of medical staff had up to date medicines management training.

Records

- Records were a combination of electronic and paper notes. All medical entries were entered on the electronic patient record (EPR), although prescription charts were hand written.
- We reviewed six sets of patient records and saw that these were complete, legible and contained sufficient detail of care and treatment provided.
- The monthly records audit in January 2017 showed that 100% of records reviewed contained all relevant information such as patient name, date of birth and hospital number.
- In endoscopy, a paper based care pathway was in use. We saw that records were stored securely and were complete, legible and signed. The pre-operative assessment included a comprehensive assessment of patient needs.
- On the PIU we saw that patient referral forms and records were left unattended in an unlocked clinical area. This meant there was a risk that records could be accessed by patients or the public.

Medical care (including older people's care)

Safeguarding

- There was a designated lead for safeguarding adults and children within the trust. Staff in medical services were able to tell us where to gain advice and how to make a safeguarding referral. The safeguarding team were available for advice during normal working hours. A safeguarding hub was available on the trust intranet with additional information to support staff.
- Staff in medical services were expected to complete training on safeguarding adults and children which included training on female genital mutilation (FGM). Clinical staff were expected to complete level two training in both of these subjects. The trust set a target of 85% for completion of safeguarding training.
- Safeguarding adults level one training had been completed by 92% of nursing staff in medical services. Safeguarding adults level two had been completed by 83% of nursing staff which was just below the trust target of 85%.
- Safeguarding children level one had been completed by 97% of nursing staff. Level two training was below target at 82%. Level three training had been completed by all relevant staff.
- Safeguarding training rates for medical staff were all below target. Only 56% of doctors had completed safeguarding adults level two and only 54% had completed safeguarding children level two.
- The nursing risk assessment booklet prompted nursing staff to ask if patients were known to social services and make consideration of whether there were any issues relating to domestic violence.

Mandatory training

- Mandatory training was a mix of face to face and e-learning sessions. The trust set a target of 85% for completion of mandatory training. Mandatory training courses included moving and handling, health and safety and fire safety.
- Training rates for medical staff did not meet the 85% target in any mandatory training module. Rates for training in these mandatory modules were 77% or below, with health and safety training completion at 54%.
- Nursing staff training figures met the 85% target in all but one of the seven mandatory modules with training rates in these modules at 90% or above. The module that did not meet target was health and safety level three where two out of six relevant staff had completed this.

Assessing and responding to patient risk

- An early warning score (EWS) system was in use in all areas. The EWS system was used to monitor patients' vital signs, identify patients at risk of deterioration and prompt staff to take appropriate action in response to any deterioration. In all the records we reviewed, we saw that scores had been calculated correctly.
- There was a procedure in place for staff to follow if a patient was deteriorating and required a medical review and a procedure to follow if an emergency transfer to a hospital with specialist facilities was required. Staff on B1 were able to explain the procedures and told us that an incident report was completed for any patient who was transferred to a different hospital in an emergency.
- There was a hospital-wide resuscitation team in place for dealing with medical emergencies. The team was led by a resident medical officer and included senior nurses and supporting staff that were trained in advanced life support.
- The PIU followed the protocols for the delivery of chemotherapy developed by the local cancer network.
- We reviewed a number of documents used on by staff on PIU to record IV infusions such as rituximab, tocilizumab and aclasta that were administered to rheumatology or gastroenterology patients on the Unit. We noted that these documents referred staff to follow criteria for administration that was set out within the associated standard operating procedures (SOPs). However, when we asked to view the SOPs, staff were not able to locate them. SOPs are put in place to ensure that appropriate procedures and checks have been followed before, during and after administration of these infusions to minimise the risk of harm to patients. The trust told us that SOPs had been updated and agreed locally and shared with staff.

Medical care (including older people's care)

- There was no evidence that patients were reviewed by a doctor or specialist nurse or that nursing staff had used a SOP before administering their treatment to ensure they were well enough to receive the infusions.
- There was a clear pathway in place for the management of patients requiring IV infusions of iron due to anaemia.
- In the acute care division, only 59.1% of all staff had completed basic life support training between February 2016 and January 2017. This was below the trust target of 85%.
- In the records we reviewed, we saw that appropriate risk assessments had been completed, including risk of venous thrombus embolism (VTE), risk of falls and pressure ulcers.
- Haematology patients with concerns about their health could access advice from the haematology specialist nurses or PIU Monday to Friday. Out of hours, patients were advised to attend the emergency department. Patients were supplied with a chemotherapy alert card to provide to health professionals in the event that they were unwell, highlighting the risk of neutropenic sepsis.
- On ward B1, nursing staff prioritised patients for consultant or medical review based on clinical priority.

Nursing staffing

- The Safer Care Nursing Tool had been used to calculate nursing staffing on B1. This had been reviewed most recently in April 2016. Staffing levels were reviewed by matrons on a daily basis and staff were reassigned to support other wards or brought in via the nurse bank or agency when necessary. Shifts were planned on B1 to ensure a band 6 nurse was always on shift.
- There was a nursing staffing escalation procedure in place which included details of actions to be taken by staff at all levels to ensure safe staffing levels. The trust collected data to compare the planned nursing coverage to the actual nursing coverage for each ward on a daily basis. Planned and actual staffing was displayed at the entrance to ward B1. On the day of our inspection, actual staffing was one registered nurse less than the planned level.
- The average fill rate for registered nurses on B1 during the day was 89.6% between September 2016 and December 2016. The fill rate for unqualified staff was 91.8%. The fill rate at night was higher at 95.5% for registered nurses and over 100% fill rate for unqualified staff.
- Staff in endoscopy moved between the two endoscopy sites at the trust.
- The rheumatology service was in the process of recruiting a specialist biological therapy nurse to support the delivery of biological therapy on PIU.
- Nursing handovers took place at each change of shift on ward B1. In addition to the nursing handover, a ward safety brief was held highlighting any specific patient safety concerns such as risk of falls, safeguarding concerns or that Deprivation of Liberty Safeguards were in place along with specific feedback from incidents of complaints. These were formally recorded and key messages were distributed to staff working on the ward.
- The trust reported an average vacancy rate of 15% for nursing staff in medical care in December 2016. There was a vacancy rate of 32% for nursing staff on ward B1. Bank and agency use on ward B1 had been 9% between April 2015 and March 2016.
- Bank or agency nurses completed a local induction on their first shift on a ward. This was an electronic form that was completed and automatically submitted to the human resources department and included essential information such as location of emergency equipment, systems for documentation and processes to follow in the event of an emergency.

Medical staffing

- A resident medical officer (RMO) was based at Halton Hospital 24 hours a day, seven days a week on a rotational basis. RMOs were supplied and employed by an external agency. This meant a doctor was on-site at all times of the day and night in the event of an emergency. The RMO was supported by advanced nurse practitioners overnight. The agency was responsible for ensuring that RMOs had the necessary training to complete their role. Information provided by the hospital showed that the RMOs were trained in advanced life support (ALS).

Medical care (including older people's care)

- A consultant ward round was held twice a week on B1 by a locum consultant. A foundation year two doctor worked on the ward for three days and the onsite RMO provided medical cover at all other times. A consultant review was provided to all patients a minimum of once per week. The trust told us they were in the process of reviewing medical cover provided to B1 as these were medically fit patients requiring rehabilitation who could have their medical care provided by a GP.

Major incident awareness and training

- There was a trust wide business continuity and major incident policy in place. All new starters were expected to complete an emergency preparedness training session. Senior staff and on-call managers undertook additional training to prepare them as 'silver commanders' in the event of a major incident.

Are medical care services effective?

Good

We rated effective as good because:

- Care and treatment was delivered in line with national guidance and best practice. The service participated in national and local audits to monitor performance and patient outcomes.
- There was a lower than expected risk of readmission and patient outcomes were generally good.
- The endoscopy unit had achieved Joint Advisory Group on Gastro Intestinal Endoscopy (JAG) accreditation.
- There was access to a wide variety of health professionals to support the delivery of effective care and they worked well together as a multidisciplinary team.
- Staff had access to the information they needed to deliver effective care and treatment to patients.

However:

- Appraisals for some staff groups did not meet the trust target. The trust could not provide us with evidence of competencies of staff working on the planned investigation unit and some staff had undertaken duties they had not been trained to perform.
- On the 2015 Lung Cancer audit, the number of patients seen by a lung cancer nurse specialist was substantially lower than the expected standard.
- Patients were at risk of being unlawfully deprived of their liberty or receiving care and treatment without consent to because staff did not follow the trust Mental Capacity Act procedure.

Evidence-based care and treatment

- Care and treatment was delivered in line with national guidance from National Institute for Health and Care Excellence (NICE), the Royal College of Physicians (RCP) and Royal College of Nurses (RCN). There were local pathways in place to support decision making in line with best practice guidance although some doctors found it difficult to locate local pathways, for example for acute kidney injury, on the trust intranet.
- In endoscopy, procedures were carried out in line with professional guidance produced by NICE and the British Society of Gastroenterologists.
- Patients received an assessment of their risk of a venous thromboembolism (blood clot) on admission and were given treatment in line with NICE quality standard (QS) 66. Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50).
- Medical services participated in all audits they were eligible to complete. In addition to this there was a trust wide audit programme covering compliance with NICE quality standards and guidance.
- Ward B1 collected data about average length of stay, destination on discharge and the level of support required or independence patients achieved on discharge. The service also monitored information about the reasons for readmission to hospital following discharge.

Pain relief

- Pain scores were recorded as part of the clinical observations rounds and patients were also asked

about pain levels during comfort rounds. We saw that patients' pain levels were recorded on early warning score documentation in line with the core standards for pain management services in the UK (Faculty of Pain Medicine 2015).

- Patients told us they were offered pain relief and it was provided in a timely way.
- There was access to a range of medications for pain relief, including patient controlled analgesia and strong pain relieving drugs. When pain was poorly controlled or difficult to manage, patients were referred to the specialist pain team for advice and support.
- Patients were offered sedation and pain relief when undergoing endoscopy. A "comfort score" was used to assess pain following any procedure in endoscopy.

Nutrition and hydration

- Patients told us that food was good quality. One patient told us that snacks were available if he was hungry in between meal times.
- On B1 nursing staff completed an assessment of nutrition and hydration needs using the Malnutrition Universal Screening Tool (MUST) on admission and reconsider this assessment on a weekly basis or when a patients needs changed. We saw this had been completed appropriately in the records we reviewed.
- A coloured tray and jug system was in use to highlight patients who needed assistance with eating and drinking. Patients were offered assistance when needed and we observed a member of staff assisting a patient at a meal time. Water jugs and cups were available at patients' bedsides.
- Patients were provided with drinks and snacks following procedures in the endoscopy unit.

Patient outcomes

- Halton Hospital took part in the 2015 National Diabetes Inpatient Audit. The hospital scored better than the England average in 12 measures of care and worse than the England average in four.
- The trust participated in the 2015 Lung Cancer Audit. This audit showed that proportion of patients seen by a Cancer Nurse Specialist was 21.5%, which was worse than the audit minimum standard of 80% and showed a substantial reduction from the 2014 figure of 65%. The proportion of fit patients with advanced Non-Small Cell Lung Cancer (NSCLC) receiving chemotherapy was 43.2%. This was significantly worse than the national level and showed a reduction from the 2014 figure of 45.5%. There was an action plan in place to increase the number of clinical nurse specialist hours at the trust to improve performance on this measure.
- The proportion of patients with NSCLC receiving surgery was 36.3%. This was significantly better than the national level and an improvement from the results of the audit carried out in 2014. The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 64%. This was similar to the national level.
- The endoscopy unit had achieved Joint Advisory Group on Gastro Intestinal Endoscopy (JAG) accreditation. JAG accreditation indicates that the service provides endoscopy in line with the Global Rating Scale Standards and is a mark of best practice.
- Overall there was a lower risk of readmission for elective admissions although there was a higher risk of readmission in the pain management speciality.
- The average length of stay for elective patients was 0.9 days which was lower (better) than the England average of 4.1 days. For non-elective patients the hospital had a higher (worse than) average length of stay of 13.8 days compared to the England average of 6.7 days. All of the non-elective admissions were for general medicine. The average length of stay for patients on B1 was 47.9 days between October 2016 and January 2017. Ward B1 is an intermediate care ward and it is usual to expect patients to have a longer length of stay in these types of units.
- Forty-seven patients had been discharged from B1 between October 2016 and January 2017. Sixty-nine per cent of these patients (27 patients) were discharged from ward B1 to their usual place of residence, with most of the remaining patients (nine patients) being readmitted to an acute care hospital due to medical deterioration. Only one patient had been readmitted to hospital following discharge.

Competent staff

Medical care (including older people's care)

- Between April 2016 and December 2016, on average 74% of staff within medical care at the trust had received an appraisal. This included 100% of allied health professionals, 78% of nursing staff and 71% of medical staff.
- Staff were able to access training internally and externally. Nursing staff had allocated mentors and allied health professionals had a named clinical supervisor.
- There was a designated training lead in the endoscopy department with an established system of induction and training. This included access to allocated lists as a trainee, twice yearly appraisals and agreed competency sign off.
- The trust had begun the implementation of the care certificate for non-qualified care assistants in January 2016. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that are expected of staff giving support to clinical roles such as healthcare assistants.
- The hospital was unable to provide us with evidence of competencies for nursing staff working on PIU or that expected competencies had been agreed. The ward manager told us that induction would involve one month as a supernumery member of staff but there was no evidence that competence to work was checked following this period. The ward manager told us there was no requirement for nurses administering cytotoxic medications to rheumatology patients to have received specific training for this. The trust told us during the inspection that competence to administer cytotoxic drugs had been assessed by a specialist nurse. Two members of staff had not been trained to administer cytotoxic drugs but had undertaken this duty prior to our inspection. Training was arranged for these members of staff following our inspection.
- Staff had been supported to develop extended skills in some areas. Specialist nurses working in haematology had undertaken training to become nurse prescribers.
- Specialist nurses in the haematology team had undertaken advanced communication skills training. This training is aimed at professionals working within cancer services and enables them to develop skills in dealing with difficult communication situations and effectively providing patients with information to make informed decisions.

Multidisciplinary working

- There was access to a range of healthcare professionals to support the delivery of care on B1. Referrals were made to physiotherapy, occupational therapy, speech and language therapy and dietetics if required. A multidisciplinary board round was held three days per week to review patient progress and assist in planning for discharge. This was attended by a nurse, occupational therapist, physiotherapist and social worker.
- Staff told us working relationships between health professionals and with outside agencies were good.
- Therapists on B1 worked closely together to plan care and treatment, often carrying out joint assessments and treatment sessions.
- Referrals to specialist nurses based at Warrington Hospital were made if required, for example the tissue viability nurse had visited ward B1 to review a patient with a pressure ulcer in the past. Staff also provided telephone advice is this was sufficient.
- Access to psychiatric input and advice could be gained through the psychiatry liaison services.

Seven-day services

- There were no consultant or junior doctor ward rounds routinely at weekends however, the RMO was on site and could be contacted 24 hours a day. Consultant advice could be accessed via the on call system at Warrington Hospital if required.
- The PIU was open Monday to Friday 8am until 6pm. There was no service provided at the weekend.
- Physiotherapy and occupational therapy was provided on ward B1 between Monday and Friday. There was no access to therapy input at weekends.
- There was access to plain film x-ray and computerised tomography (CT) scanning 24 hours a day a Halton Hospital. Magnetic resonance (MR) imaging was available from 8am to 8pm seven days a week.

Access to information

- The endoscopy department had a full set of policies based on NICE guidance that was easily accessible on the trust intranet.
- Letters were sent to GPs on discharge from B1 to inform them of the reasons for admission and care and treatment provided during the patients' hospital stay. Referrals were also made to other community health staff such as district nurses and AHPs to ensure continuation of the patient's care.
- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments, and medical and nursing records.
- There were computers available on the wards we visited, which staff accessed for patient and trust information. Policies, protocols and procedures were kept on the trust's intranet, which meant staff had access to them when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust reported that between January 2014 and December 2016 Mental Capacity Act (MCA) training had been completed by 77% of staff within Medical Care. This was below the trust target of 85%.
- There was a trust wide Mental Capacity and Deprivation of Liberty Safeguard Operational Procedure in place which set out the legal requirements of the Mental Capacity Act (2005) and contained information and procedures for staff to follow when there was reason to doubt a patient's capacity to consent.
- Staff had a basic understanding of the principles of the Mental Capacity Act (2005). They gave us examples of when they had attended best interest meetings for patients who lacked capacity to make their own decision about a specific aspect of their care. However, when we reviewed the notes of one patient who had deprivation of liberty safeguards (DoLS) in place, we saw that there had been no documented assessment of the patient's capacity to consent to the deprivation of liberty. We saw that this was a widespread issue affecting other services at the trust and you can read more about this in our report on medical care at Warrington Hospital.
- Patients told us they were given sufficient information during the consent process to make an informed decision about having an endoscopy. We checked the records of three patients in endoscopy and saw that consent had been gained appropriately in all three cases, including consent being obtained prior to the procedure and confirmation of consent on the day.

Are medical care services caring?

Good

At out last inspection we rated caring as good and we have maintained this rating because:

- Staff were kind, caring and compassionate. They were sensitive in their communications with patients and understood and respected individual needs. Privacy and dignity was maintained at all times in the clinical environment.
- Patients were involved in making decisions about their care and treatment and their families were also involved. They were given information and time to ask questions.
- The endoscopy unit used a local patient survey alongside the NHS friends and family test. 94% of patients who responded would recommend the service to their friends and family.
- The emotional needs of patients were considered and staff made referrals and sign posted patients to other sources of emotional support. A complementary therapist attended the planned investigation unit one day a week.

Compassionate care

- We observed staff greeting patients in a friendly way and introducing themselves by name. They communicated with patients sensitively in difficult situations.
- Patients told us their privacy and dignity had been maintained at all times. We saw that staff took all possible steps to promote privacy and dignity for example by drawing bedside curtains and consulting with them in private where possible.

- Feedback from patients we spoke with was positive. They told us staff were very friendly, approachable and gave them time to discuss any particular needs.
- They said that care was "fabulous" and staff were "very nice".
- The endoscopy unit used a departmental patient survey to gain feedback about patient experience. On the most recent review of the survey, all patients had reported they had been given enough privacy and dignity before, during and after their procedure.
- The endoscopy gathered patient feedback on the care provided using the NHS Friends and Family Test (FFT). The NHS FFT asks patients who likely they are to recommend a service to their friends or family. Response rates varied over the last six months from no responses to a 30% response rate one month. The overall recommend score was 94% between August 2016 and January 2017. The planned investigation unit had only two responses during this six month period. The FFT was not used on ward B1 and the trust did not provide us with any other patient feedback for this ward.

Understanding and involvement of patients and those close to them

- Patients were given time to ask questions about their care and treatment in endoscopy. Staff answered questions and provided reassurance to patients before, during and after procedures.
- Patients and their families were involved in planning care, treatment and discharge on B1. Families were updated on their relatives' progress and made to feel welcome on the ward.
- Patients told us they were given enough information about their treatment and felt that staff listened to and respected any concerns they may have.
- Patients were given individualised information and advice following a holistic needs assessment in the haematology team.

Emotional support

- There was a range of specialist nurses working across the trust and within medical services. This included specialist nurses in rheumatology, haematology, diabetes and tissue viability. Staff could access for advice and support for patients from Warrington Hospital and some were based at Halton Hospital.
- Specialist nurses gave patients receiving chemotherapy on the PIU information and advice about the Delamere Support and Information Centre at the hospital. The Delamere is a specialist cancer information centre provided by a charity. This centre offered a range of services including counselling, information and advice and complementary therapies for anyone affected by cancer.
- In addition to the emotional support offered at The Delamere, a holistic therapist attended PIU each week to offer complementary therapy to patients receiving chemotherapy.

Are medical care services responsive?

Good

At our last inspection we rated responsive as good. We have maintained this rating because:

- Between December 2015 and November 2016 the trust's referral to treatment time (RTT) for admitted pathways for medical services had been better than the England overall performance.
- Adjustments were made for patients with individual needs such as a learning disability or who required translation services. Dementia friendly signs were in place in most areas. Individualised care plans were used for patients living with dementia and carers were encouraged to stay with this patient group.
- Services had been planned to meet the needs of local people in conjunction with other local stakeholders and plans were in place to further develop these services in the future.

However:

- There was no named lead for learning disabilities within medical services and no way of flagging patients with a learning disability on the electronic patient record system.

Medical care (including older people's care)

Service planning and delivery to meet the needs of local people

- Medical services had been planned and developed with a number of local partners and networks to meet the needs of local people and also with consideration to the sustainability of services.
- Ward B1 was managed on the behalf of the local clinical commissioning group (CCG) and we saw evidence of joint working between the two organisations to best meet the needs of local people.
- The endoscopy unit had been opened in February 2015 to offer additional capacity for gastrointestinal endoscopy and to offer the residents of Halton this service closer to home.
- There were plans to develop Halton Hospital into a health and wellbeing campus including new approaches to delivering health care to the local population. This was a collaboration between the trust, the CCG and the local authority.

Access and flow

- Admissions to ward B1 were co-ordinated by the Clinical Commissioning Group. The ward accepted referrals from other inpatient wards at the trust or from other trusts within the region where the patient was resident in Halton. Referrals were also taken from the Rapid Access Rehabilitation Service and from community health teams to avoid admission to an acute ward. The waiting list was managed by the RARS and if beds were not available on B1, beds at alternative intermediate care units were pursued.
- Appointments were provided for admissions to the PIU and for day case endoscopy.
- Bed occupancy rates on B1 were 94.4% between October 2016 and January 2017. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Between December 2015 and November 2016 the trusts' referral to treatment time (RTT) for admitted pathways for medical services had been better than the England overall performance. The latest figures for January 2017 showed 90.9% of this group of patients were treated within 18 weeks versus the England average of 89.1%. With the exception of August 2016, the trust has been performing better than or the same as the England average.
- There were low waiting times for diagnostic endoscopy. The average wait for an endoscopy was around two weeks between November 2016 and January 2017 with no patients waiting over five weeks during this time period.
- Patients attending for a day case endoscopy were given information about what to expect following their procedure, when to seek medical advice and who to contact during and out of hours.

Meeting people's individual needs

- The electronic patient record system could be used to flag patients living with dementia or those with a cognitive impairment. There was no way of flagging patients with a learning disability.
- The hospital supported John's Campaign which champions the rights of carers to stay with people living with dementia whilst they are being cared for outside of their usual environment.
- There was no named lead for learning disabilities within medical services. Senior staff recognised this was a gap in within the service. This meant that staff may have difficulty accessing advice, support and training to enable them to meet the needs of patients with a learning disability and may mean that the needs of this patient group were not considered when planning and developing services.
- We saw communication aids for use with patients who experienced difficulties communicating.
- Where patients were living with dementia, the service used a "This is me" document. "This is me" is an information document developed to support people receiving care who have any form of cognitive impairment or difficulty communicating their needs and is a way of supporting person centre care. The service also used "passports" outlining preferences and how best to care for patients with a learning disability.
- There were dementia friendly signs in the endoscopy unit and ward B1. The environment on PIU did not

have any dementia friendly signs in place. There was a challenging behaviour care plan available to use where patients may display behaviour that was difficult to manage along with guidance to staff to identify non-pharmacological ways of managing these behaviours. The service encouraged staff to use an ABC chart (antecedent, behaviour, consequence) to identify triggers and ways to minimise these.

- On ward B1, there was access to activities such as board games to enable patients to pass the time. In the day room there were tea and coffee making facilities, additional games and 'twiddle muffs' that are used by people living with dementia to occupy their hands. There was also access to a secure garden area for patients to use.
- On the most recent record keeping audit in January 2017, all relevant patients had an individualised dementia care plan in place.
- In endoscopy, staff gave an example of how they had supported a patient with a learning disability. The patient had been given a tour to make the unit more familiar and their carer had been allowed to stay with the patient during the procedure.
- In endoscopy, recovery bays were divided into male and female areas to promote privacy and dignity.
- On ward B1, extended visiting times were in use to allow relatives to visit their family member at more convenient times or to support them over extended periods of time. Family members were able to stay with their relatives on the PIU whilst receiving their treatment.
- There was access to face to face, telephone or written translation services 24 hours a day. Staff also had access to a local deaf persons' organisation that provided sign language interpretation when required.
- The endoscopy department had introduced the use of Entonox as an alternative to traditional anaesthetic drugs. This had increased patient satisfaction with the service as they no longer needed a relative or friend to stay with them overnight following the procedure.
- Equality and diversity training had been completed by 93% of nursing staff and 65% of medical staff. The trust target was set at 85%.
- There was a multi-faith prayer room and chapel at the hospital and access to chaplaincy services 24 hours a day.

Learning from complaints and concerns

- Information about the trust's Patient Advice and Liaison Service (PALS) and how to make a complaint was on display in the areas we visited.
- In endoscopy, we saw the department also displayed information about changes they had made as a result of complaints or concerns, for example displaying information about any delays to appointment times and which staff were on duty.
- Learning from complaints was discussed at ward safety briefs and team meetings. Staff told us they were given feedback about complaints from other areas of the trust.
- The trust had recently reviewed the way complaints were handled and agreed a new complaints and concerns policy, including a reduced time scale of 30 days for responding to complaints and allocating complainants an agreed point of contact in the patient experience team.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The clinical governance structure within the acute care division was not sufficiently embedded into practice. We saw no evidence that governance meetings were held in most of the clinical business units and no evidence that information from the trust wide governance meeting was shared with clinical business units via the divisional meeting.
- We saw no evidence that risk, risk management and quality measurement was discussed within most clinical business units. Risks on the risk register did not have complete details of actions taken to mitigate risks or documented evidence of the outcome of progress reviews.
- There had been no feedback or active public engagement in regard to ward B1 or the PIU.

However:

- There was a positive and open culture. Staff described communication as good and leaders were approachable and visible. The appointment of a new chief nurse was seen as a positive development.
- The endoscopy service actively sought patient feedback and regularly reviewed this feedback to continuously improve the service it offered.

Leadership of service

- Ward B1 and the PIU were managed within the acute care division within the specialist medicine business unit (B1) and the diagnostics business unit (PIU). Both of these CBUs were managed under the acute care division. The endoscopy unit was managed by the digestive disease business unit which sat within the Surgery and Women's and Children's Health division. This was a new management structure that had come into effect in April 2016. Services had been allocated to CBU based on a patient pathway rather than the traditional hospital model of medicine and surgery. Each CBU was led by a nurse, doctor and operations manager. Leaders in each CBU were being supported to develop their leadership skills through internal and external courses. Staff spoke positively about the reorganisation of management structures that were more centred on a patients care.
- A consultants meeting was held in each CBU. Some medical staff who were managed within the Surgery and Women's and Children's Health division had requested that they still had the opportunity to attend a meeting of the medical specialty. An additional meeting was set up and supported by the Chief of Service to address this need. Matrons and ward managers held a weekly meeting with ward based staff.
- There was a monthly management meeting with the operational manager on PIU. Consultants regularly using PIU met every other month to discuss the unit and its operation. There was a similar meeting in endoscopy.
- Ward B1 was managed by the specialist medicine CBU. The matron for specialist medicine visited ward B1 twice per week and held a daily telephone call with the ward manager or nurse in charge to ensure there was a good level of communication between sites.
- Staff told us that they felt well-supported by their managers despite being based on a different site.
- Senior staff told us that the executive team was approachable and they felt confident in raising issues with the team if required.

Vision and strategy for this service

- The trust mission was to provide high quality, safe and integrated healthcare. There were an established set of values at the trust that were to work as one, excellence, accountable, role models and embrace change. Pin badge awards were issued to staff who displayed these values consistently.
- Staff had mixed awareness of the overall vision and strategy of the acute care division but had better awareness of the aims and objectives of their clinical business unit or individual team aims.
- There were divisional objectives focussed around the trust's key focuses of quality, people and sustainability. We noted that although there were objectives and associated actions in place, there were not always specific measureable outcomes attached to these objectives. For example, one of the measures of success was listed as a reduction in delayed transfers of care and there were no targets defined for the reduction in nursing or medical vacancies.

Governance, risk management and quality measurement

- There was a defined clinical governance structure within the service and a system of feeding key information up and down within the trust. Each clinical business unit (CBU) had an allocated governance lead with a dedicated governance manager within the divisions. However, this was a new structure with a recently introduced "quality bilateral" where key governance information from each CBU could be discussed. The governance structure and process for the new CBUs was not fully understood by relevant staff.

- There was a monthly clinical governance meeting held within the division with a standard agenda although we noted that this meeting was described as "informal" in the information provided by the trust. We reviewed the minutes of the most recent meetings and saw that incidents, NICE guidance and clinical audit were discussed at these meetings. Senior staff told us that information was shared at this meeting from the trust wide governance meeting and cascaded back to staff through CBU meetings and team meetings. However, when we reviewed the minutes the trust provided we did not see evidence that this had happened. The ward manager on PIU told us she had not attended the new clinical governance meetings.
- Senior staff told us there were monthly CBU governance meetings. We requested the minutes of these meetings but the trust only supplied the minutes of meetings from the airways, breathing and circulation CBU. We noted that at the most recent divisional meeting in February 2017, the chief of service and associate director of operations had discussed the need to ensure these meetings were held within the CBUs with adequate attendance and were quorate, suggesting that meetings had not been held.
- There was a medical cabinet of senior doctors who met every three months that was chaired by the medical director and attended by around 25 senior doctors. We asked the trust to provide us with the terms of reference for this group to determine what the function of the cabinet was but they did not provide this information.
- A divisional dashboard was in use to monitor quality, patient experience and performance along with information about staff vacancies and sickness and finance. Key metrics were displayed on this dashboard and rated as green, amber or red depending on compliance against each metric.
- There was a divisional and departmental risk register in place. Risks were managed using a process set out in a trust wide risk management policy. Risks were given a risk rating based on the likelihood of an event happening and the severity or impact this event would have. Risks scoring 12 or above on this rating were escalated to the divisional register.
- We reviewed the register and saw that key risks within the service had been identified. However, we noted that risk mitigation actions were limited and there were no progress reviews on any of the five action plans we reviewed. For example, a patient safety risk due to the number of nursing vacancies had been included as a high risk on the register. The associated action plan did not contain sufficient information about what actions were being taken to reduce this risk and did not reflect the full range of actions senior staff and managers told us were taken. Although the risk had been reviewed in January 2017, there was no documented outcome of this review.
- We saw that risks and the risk register were discussed at the airways, breathing and circulation CBU meetings including any new risks added or changes in risk ratings during the previous month. These meetings also included discussion of key safety issues, learning from incidents and complaints and compliance or actions plans from clinical audit. We did not see any evidence from other CBUs.
- Staff told us that the reorganisation of services within CBUs had led to improved communication between teams providing services to the same patient groups. For example, the PIU and haematology services were now managed within the same business unit.
- The haematology team held a monthly team meeting where they discussed outcomes of clinical audit, mortality and morbidity and service developments.

Culture within the service

- Staff were positive about the work they did and reported that the hospital was a good place to work. Staff felt appreciated for the work they did.
- Staff told us they would be confident in raising concerns and reported an open culture.
- The trust reported an average turnover rate of 9.6% for nursing staff in medical services. The rate on B1 was lower than this at 7.6%. The turnover rate for medical staff was 42.53% during the last financial year.
- The trust reported an average sickness rate for nursing staff of 4.1%. The sickness rate on ward B1 was 0.1%. The rate for medical staff was 1.38%. These figures were below the trust target of 4.2%.

Medical care (including older people's care)

Public engagement

- In endoscopy, a patient feedback form was available in every cubicle and also used the NHS Friends and Family test. The service regularly reviewed patient feedback to continuously improve the service it offered.
- Outside ward B1 there was a "Your Ideas" board highlighting examples of how the ward had improved following suggestions from the public. This type of board can encourage patients and the public to make suggestions about how to improve care offered to patients. For example, a suggestion had been made to improve seating at the bedside and in the discharge area. The ward had listened to the feedback and reorganised the discharge area to include tables and improved bedside seating. The board also displayed compliments received from patients and relatives.
- There had been no feedback or active public engagement in regard to the PIU.

Staff engagement

- The acute care division had a social media account that could only be accessed by authorised staff. The division shared information such as learning from incidents or complaints, key feedback from meetings or messages of thanks and congratulations with staff through this account. Senior staff were able to monitor how frequently the page was accessed and by how many staff and told us this had been a successful way of engaging with staff.
- The trust used pin badge awards to recognise individuals who consistently displayed the trusts' values. Long service was recognised through the trusts "Thank you" awards.

Innovation, improvement and sustainability

- The acute care division was actively managing the number of registered nurse vacancies using a recruitment and retention strategy, alongside reviewing the roles of nurses on medical wards. Some of the changes they had implemented included increasing phlebotomy cover, ward clerk hours and band two healthcare workers to release time for the nurses to carry out registered nursing duties.

Surgery

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

We visited Halton general hospital and the Cheshire and Merseyside Treatment Centre (CMTC), as part of our announced inspection between 7-10 March 2017. We also carried out an unannounced visit on the 23 March 2017.

A range of day case and elective surgical services were provided from two separate locations within the grounds at Halton. The main hospital site included four theatres, an inpatient ward and a day case unit and provided services such as urology, ear, nose and throat (ENT), and general surgery.

The Cheshire and Merseyside Treatment Centre (CMTC), was a purpose built building with four theatres, a day case unit and an inpatient ward that provided elective orthopaedic surgery.

As part of the inspection, we visited the theatres, ward B4 (the elective surgical ward) and the day case unit at the main hospital site. We also inspected the theatres, the inpatient elective surgery ward at the Cheshire and Merseyside Treatment Centre.

We spoke with 15 patients. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, ward managers, the theatres managers,

We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed to our aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

Surgery

Summary of findings

At the previous inspection in January 2015, we rated this service as good. Following this inspection we have maintained the overall rating because:

- We found there was a good culture of incident reporting in order to learn and share good practice.
- Mandatory training compliance across the division had improved following the last inspection and although training in all areas was not above the trust target, improvements were evident.
- Staff could identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing or medical emergencies.
- The Service participated in clinical audits through the advancing quality programme. The advancing quality programme aims to improve the quality of care patients receive in hospitals across the North West of England by measuring and reporting how well the hospitals are performing. Performance data in the April 2015 to March 2016 hip and knee audit showed excellent results across all six measures, ranging from 99% to 100%.
- All patients and relatives we spoke with told us that that all members of staff treated them with dignity and respect.
- We observed many positive interactions between staff and patients during our inspection. We saw that staff were professional and friendly and created a relaxed friendly environment
- The trust monitored the number of cancelled operations on the day of surgery. Performance data provided by the trust showed that the average number of cancelled operations at the Halton site from February 2016 to January 2017 was low at 9.3% and at CMTC, 5.7%.
- There was a clear governance structure to support governance and risk management, and staff had clearly defined roles, responsibilities and reporting structure.

However:

- We found that the anaesthetic machines were not always being checked in accordance with the Association of Anaesthetists for Great Britain and Ireland (AAGBI). Daily checks of anaesthetic machines should be recorded daily. This was highlighted to the theatre manager immediately to ensure compliance. Following the inspection the trust has introduced a system to ensure that these checks are recorded.
- We found six out of date stocks out on various trolleys. For example, we found an out of date suction catheter and sutures. This was highlighted immediately to theatre staff and all out of date stocks removed and replaced.
- We saw on two occasions that the World Health Organization (WHO) checklist in surgery was not followed fully. We observed that in one surgical procedure, no formal introductions of the team were completed in the 'time out' section of the checklist. In another surgical procedure, the anaesthetist was not present for the identification check at the 'sign in' section of the checklist. The WHO checklist is designed to eliminate the occurrence of surgical errors when followed correctly and requires all staff to take part.
- Since March 2016 there had been three never events relating to surgical procedures at the Halton site. Two of these never events occurred in March 2017. 'Never events' are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented by healthcare providers.

Surgery

Are surgery services safe?

Requires improvement

At the previous inspection in January 2015, we rated safe as good. Following this inspection we have rated safe as requires improvement because:

- We found that the anaesthetic machines were not always being checked in accordance with the Association of Anaesthetists for Great Britain and Ireland (AAGBI). Daily checks of anaesthetic machines should be recorded daily. This was highlighted to the theatre manager immediately to ensure compliance.
- Since 2016 there had been three never events. Two of these never events occurred in March 2017 and related to preventable errors made during surgery. These events can be minimised by the appropriate use of the World Health Organization (WHO) checklist. 'Never events' are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented by healthcare providers.
- We saw on two occasions that the (WHO) checklist in surgery was not followed fully. We observed that in one surgical procedure no formal introductions of the team were completed in the 'time out' section of the checklist. In another surgical procedure the anaesthetist was not present for the identification check at the 'sign in' section of the checklist. The WHO checklist is designed to eliminate the occurrence of surgical errors when followed correctly and requires all staff to take part.
- In recovery, we saw that national guidance was not being adhered to ensure there were enough suitably qualified recovery nurses on shift with advanced life support training. We found there were no recovery nurses on shift who had completed advanced life support training.
- We found six out of date stocks out on various trolleys. For example, we found an out of date suction catheter and sutures. This was highlighted immediately to theatre staff and all out of date stocks removed and replaced.

However:

- We found there was a good culture of incident reporting in order to learn and share good practice.
- All floor areas and bed spaces on the surgical wards we visited appeared visibly clean. We saw that there were cleaning schedules were signed and dated to show that areas were clean.
- We saw that patient records were structured, legible, complete and up to date and contained risk assessments and care plans that were individualised to the patient's needs.
- Staff could identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing or medical emergencies.
- Mandatory training compliance across the division had improved following the last inspection.

Incidents

- The hospital had an up to date trust incident reporting policy for staff to follow, which was available to them through the hospital intranet.
- All staff we spoke with at Halton hospital had a good understanding of the reporting system and could access the system from the ward or theatre. All incidents, accidents and near misses were entered onto an electronic system. Staff gave examples of the type of incidents they reported. For example, if a staff member was asked to cover a shift elsewhere within the trust or following a patient fall.
- Data we received from the trust showed between January 2016 and December 2016 there had been 7564 incidents reported across the trust. Of these 1177 (16%) occurred within theatres or inpatient surgical wards across the Warrington and Halton sites.
- We reviewed the incident reports for both Halton and CMTC and saw that between January 2016 and January 2017, 398 (34%) incidents had been reported.
- Incidents were reviewed and investigated by the appropriate manager to look for improvements to the service. Moderate and severe incidents were also investigated through a process of root cause analysis

(RCA), with outcomes and lessons learned shared with staff. We saw two RCA reports, which had been completed, with recommendations, action plans, and lessons learnt which confirmed the process.

- We saw evidence that hospital action reports were shared across the division. These reports highlighted errors in practice and key action points. We also saw evidence that key learning with regards to incidents and adverse events were discussed in daily safety briefings.
- We reviewed the incident recording logs and found that there was a broad spread of incidents recorded. These included cancellation of surgery and patients who were not suitable for surgery at Halton due to their complex needs. This showed that staff reported appropriate incidents that occurred at the hospital.
- The trust had reported one never event in 2016 relating to wrong site surgery. 'Never events' are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented by healthcare providers. Prior to and following the inspection, two further never events occurred in March 2017, relating to wrong site surgery and retention of a swab following surgery. We saw that initial investigations were underway to establish the cause of the never events and appropriate actions taken to ensure all nursing and medical staff followed policy and procedures. This included 1:1 sessions with each member of the theatre staff to revisit the standard operating procedure for surgical procedures and observational checks completed by managers at the trust. An immediate action plan was initiated while the incidents were being investigated. The clinical director present to the medical staff and the patient safety subcommittee.
- Although the never events had occurred at Halton hospital, all staff we spoke with at Warrington hospital were aware of the incidents that had occurred which demonstrated that key information was shared across both trust sites.
- The trust reported low numbers of surgical site infections (SSI) following surgery. Between April 2015 to April 2016, there had been four incidents of SSI in knee replacement surgery and three incidents of SSI in hip replacement surgery. SSI's were monitored by the orthopaedic department in-line with National Institute for Health and Care Excellence (NICE) guidelines for quality standards for orthopaedic surgical site surveillance. The surveillance information collected during April 15 to March 16 showed there had been 672 hip and knee operations and indicated that the orthopaedic joint replacement infections were minimal and mainly superficial infections. This indicated that care and treatment was being delivered with high regard to infection prevention procedures.
- Incidents and adverse events were discussed at the quality and safety meeting, and we saw that incidents were discussed at daily safety huddles.
- From April 2015, all providers were required to comply with the Duty of Candour Regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were aware of the duty of candour regulation; ensuring patients received a timely apology when there had been a defined notifiable safety incident. We saw examples of where duty of candour had been applied with regards to incidents and complaints.

Safety thermometer

- The safety thermometer is a tool for measuring, monitoring, and analysing patient harms and 'harm free' care. Data was collected on each month to indicate performance in key safety areas, for example, new pressure ulcers and falls.
- The trust monitored the incidence of pressure ulcers, falls, and venous thromboembolisms (VTEs). VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients.
- From January 2015 to January 2016, the trust reported there had been no falls resulting in harm, and three hospital acquired pressure ulcers across the surgical division. We saw that incidents regarding falls and hospital acquired pressure ulcers were reported by staff using the electronic incident reporting system.
- The surgical wards displayed information as to the number of falls, and pressure ulcers that had occurred on the ward to highlight their safety performance to patients and visitors.

- Guidelines from the National Institute for Health and Care Excellence (NICE) recommend that all patients should be VTE risk assessed on admission and reassessed 24 hours after surgery. Data provided by the trust indicated that the year to date performance up to December 2016 for patients being assessed for VTE was 93%. This was not line with the trust target of 95%. However, performance in December 2016 was in line with the target, and all records we reviewed indicated that patients were assessed for VTE.
- From July 2016 to December 2016, there had been 11 incidents of VTE across the surgical division. Of these, seven had been with trauma and orthopaedics. The trust provided information to support that RCA's had been completed in 10 of the 11 incidents.
- In January 2017, an audit to identify the percentage of patients as requiring prophylaxis following VTE risk assessment, who are given the defined treatment within required timescale was completed. The audit found 86% compliance against a target of 95%. An action plan had been developed to ensure future compliance. The action plan included investigation into the electronic system providing an alert that VTE had not been completed. Staff we spoke with informed us that they checked that VTE had been assessed on admission and all records we reviewed showed that VTE assessments had taken place.
- Staff used anti embolism stockings on patients following surgery to reduce the risk of them acquiring VTE.

Cleanliness, infection control and hygiene

- The hospital followed their infection control policy, which included hand hygiene, use of personal protective equipment (PPE) such as gloves and aprons, to prevent the potential spread of infection.
- At the pre-operative assessment stage, staff screened patients for Meticillin-resistant Staphylococcus aureus (MRSA) and Meticillin-sensitive Staphylococcus aureus (MSSA). This is in line with Department of Health: Implementation of modified admission MRSA Screening guidance for the NHS (2014). MRSA and MSSA are infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated.
- If a patient was identified at the preoperative assessment with carrying an infection such as MRSA or MSSA, they received treatment for the infection in the five days leading up to the surgery. The scheduling of theatre lists allowed for patients who had infections to be last on the theatre list. Patients identified with MRSA could be isolated in their rooms to prevent cross infection risks.
- Data provided by the trust showed that between December 2015 and December 2016 there had been no reported cases of MRSA and no cases of MSSA attributed to Halton hospital or CMTC.
- Staff were able to explain that any patient who attended or acquired and infection would be barrier nursed to minimise the spread of infection.
- All floor areas and bed spaces on the surgical wards we visited appeared visibly clean. We saw that there were cleaning schedules were signed and dated to show that areas were clean.
- Sluice rooms and storage areas across the surgical wards appeared clean and free from clutter.
- We observed staff following the local policy and procedure when scrubbing, gowning and gloving prior to surgical interventions. When a procedure had commenced, movement in and out of theatres was restricted. This minimised the infection risk. We saw that all staff in theatres wore the correct attire; piercings were removed, and saw that hair including facial hair was covered. We saw that at the end of surgery gowns were removed ready to be laundered.
- We saw that waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the HTM 07-01, control of substance hazardous to health (COSHH) and health and safety at work regulations.
- We saw that locked separate bins were in use for confidential waste. This ensured that sensitive data and patient identifiers were destroyed securely.
- We found equipment was visibly clean throughout the surgical wards, and staff had a good understanding of their responsibilities in relation to cleaning and infection prevention.

- In theatres and the wards, we found all equipment appeared to be clean. However, we saw in the theatres corridor at Halton, there were cracked and damaged ceiling tiles, and visible dust around the vents at the main reception.
- In theatres we saw that laryngoscope handles and disposable blades on the difficult airways trolley that were not in packaging and saw no evidence that they had been decontaminated.
- Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare arms below the elbow" guidelines. Hand gel was readily available in all clinical areas and entrances to wards and we observed staff using it appropriately.
- We saw Personal Protective Equipment (PPE), being used on surgical wards on a regular basis in line with hospital policy. PPE was also provided for visiting relatives when needed.
- The infection control matrons produced a monthly infection control report, which included results from hand hygiene, commode, work wear compliance, environment cleanliness and high impact intervention (catheter care) audits. We reviewed the report for ward B4 and CMTC ward in February 2017, which showed there was 100% compliance in hand hygiene and environmental hygiene. From our observations, we found the ward to be clean and all staff adhered to the principles of good hand hygiene.
- The hospitals Patient Led Assessment of the Care Environment (PLACE) audit for 2016 showed the hospital scored 98% for cleanliness, which was in-line the England national average of 98%.

Environment and equipment

- The wards and theatre areas we visited were generally well maintained, free from clutter and provided a suitable environment for treating patients.
- All fire escapes were kept clear and signposted for use in an emergency.
- There was sufficient storage space on the wards in the theatres. We saw that all surgical wards and theatre medical consumables such as syringes and dressings were appropriately stored in tidy and well-organised storage containers.
- We found sharps bin across theatres and wards to be labelled and used appropriately to prevent needle stick injuries.
- Records indicated that equipment was maintained and used according to manufacturer's instructions. There was sufficient equipment to maintain safe and effective care. We saw service schedules were kept for all electrical equipment with service dates for scheduled servicing.
- We saw that medical gases in theatres were appropriately stored and secure.
- Managers informed us that upon failure of any equipment an external contractor provided replacements quickly to avoid delays in surgical procedures taking place.
- The service had arrangements with an external contractor for the sterilisation of reusable surgical instruments. Managers informed us that the contractor provided a good service and any errors were rectified usually the same day. Records were kept of any errors in providing suitable reusable equipment in order for senior managers to monitor the ongoing contract.
- A theatre maintenance schedule was in operation to ensure that quarterly, half- yearly and annual revalidation of theatre maintenance was co-ordinated. The schedule included building maintenance and the maintenance of the air-handling units to ensure optimum performance of air extraction.
- Daily morning surgical meetings were held to ensure that all staff had the required equipment for the surgeries planned for that day. We observed in theatres staff checking and setting surgical instruments. The check was verbal and visual between two staff in-line with standards and recommendations for safe practice.
- Records indicated that resuscitation equipment for use in an emergency in operating theatres and ward areas, were regularly checked and documented as complete and ready for use. The trolleys were secured with tags, which were removed and replaced following checking the contents of the trolley.
- At the time of inspection, we found that the anaesthetic machines were not always being checked in accordance with the Association of Anaesthetists for Great Britain

and Ireland (AAGBI). Daily checks of anaesthetic machines should be undertaken and recorded on a daily basis. This was highlighted to the theatre manager immediately to ensure compliance.

- In theatres across Halton hospital and Cheshire and the Merseyside Treatment Centre (CMTC, we found six out of date stocks on various trolleys. For example, we found an out of date suction catheter, sutures and calcium chloride injection ampoules. This was highlighted immediately to theatre staff and all out of date stocks removed and replaced.
- There were systems to maintain and service equipment as required. Medical devices we looked at indicated that equipment had been tested appropriately to ensure that it was safe to use. Portable appliance testing (PAT) is a process by which electrical appliances are routinely checked for safety once a year.
- We saw in in Halton theatres that the treatment room and theatre three recovery did not have access to an emergency call bell, and instead had a horn to summon help in an emergency. Staff reported that this had been escalated to the senior team. Senior managers informed us that the use of the horn was tested and highlighted to new staff as part of their induction process to ensure they were aware of its use. Staff confirmed that the horn was tested regularly to ensure it was ready for use.
- Recording systems were in place to ensure that details of specific implants and equipment could be provided rapidly to the health care products regulator. An implant register was kept within theatres of all cosmetic implants and prosthesis, and serial numbers noted. We reviewed the register, and found that it was legible, up to date and contained the necessary serial numbers of implants or prosthesis used.
- In theatres, we observed transfers of patients to the operating table. We saw the anaesthetist led this, and appropriate equipment was used.

Medicines

- There were arrangements in place for managing medicines and medical gases. Nursing staff were able to explain the process for safe administration of medicines and were aware of policies on preparation and administration of controlled drugs as per the Nursing and Midwifery Council Standards for Medicine Management. We saw that there was an up to date policy for the safe storage, recording of, administration and disposal of medicines. This was available for staff on the intranet.
- There were two pharmacists based at the Halton site providing pharmaceutical services to the wards. One pharmacist supported the dispensary and day case areas, and the other visited the inpatient areas.
- We saw that medicines were ordered, stored and discarded safely and appropriately and medical staff were aware of the policy for prescribing antimicrobial medicines.
- We observed that all medicines were appropriately stored in suitable locked cabinets, and a member of qualified nursing staff held the keys.
- Records on the ward and theatres indicated that controlled drugs were generally checked twice daily and were signed as correct by two staff.
- We observed that controlled medicines stocks were in date.
- Medicines that required storage at temperatures below 8ºC were appropriately stored in medicine fridges. Records indicated that staff completed daily fridge temperature checks in line with the hospital policy.
- We reviewed 10 prescription charts and found them all to be legible, dated and signed, allergies documented and saw antibiotics were administered appropriately.
- A quarterly medicine management report highlighted areas where medication incidents had occurred across the division. The report was disseminated across the trust to enable shared learning. The report highlighted medication errors by location and by type in order to address compliance and training needs. For example, following an insulin incident the diabetic team had arranged further training for staff. Staff we spoke with confirmed that extra training was available following a medicine incident.
- Staff informed us that following a medication incident, lessons learnt were shared at the daily ward safety brief and individual staff completed a medicine competency if a dispensing error was made.

Records

- The hospital staff followed their trust patient records policy, which included confidentiality of patient records.
- The trust used a mix of electronic and paper patient records to detail the care and treatment of patients. We found that all records were securely stored in each area we inspected. The trust was moving towards a paper free records procedure to ensure records were secure and contemporaneous.
- At the time of inspection, we saw patient personal information and medical records were managed safely and securely, in line with the data protection guidelines. However, we observed a records trolley on the CMTC ward was out on the ward and not locked.
- Patient records we viewed were integrated to ensure that they contained all information from pre-assessment, through to surgery, to the ward. This provided staff with the necessary information as to the care and treatment required for each patient.
- We looked at 10 patient records. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for falls, venous thromboembolism, pressure care and nutrition and were reviewed and updated on a regular basis.
- Patient records showed that nursing and clinical assessments were carried out before, during and after surgery. We saw these were documented correctly.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.
- Patient records were audited on a monthly basis. The audit looked at a random sample of records across the surgical division to ensure compliance with the trust management of medical records, record keeping standards. In the January 2017, surgical division records audit showed a compliance rate above the standard 75%. The report provided an action plan for improvements in future audits that included further training for ward staff. Staff we spoke with confirmed that they were confident in the use of the paper and electronic records used.

Safeguarding

- The trust had a senior named nurse lead for safeguarding for both adults and children. All staff we spoke with were aware of their safeguarding adults and children responsibilities, and who to contact if guidance was required.
- Staff received mandatory clinical skills training in the safeguarding of vulnerable adults and children. This included an awareness of female genital mutilation (FGM).
- The hospital data provided at inspection showed that up to January 2017, 100% of staff in CMTC and Halton theatres had completed safeguarding adult's level 1 training and 92% (CMTC) and 100% (Halton) staff had completed safeguarding adult's level 2. This was above the trust target of 85%.
- Compliance in safeguarding children level 1 and 2 at both Halton theatres and CMTC theatres was 100% with the exception of Halton theatres compliance with safeguarding children level 2 training, which was 93%.
- Data provided by the trust showed that up to January 2017, 93% of nursing staff on surgical ward B4, and 95% on the CMTC ward had completed safeguarding adult's level 1 training and 71% of staff across both wards had completed safeguarding adult's level 2 training. The trust target was 85%
- Training compliance in safeguarding children level 1 and 2 for CMTC ward and ward B4 was variable at 81% and 48% for CMTC ward and 86% and 64% on ward B4. This was below the trust target of 85%.

Mandatory training

- Records we reviewed confirmed that mandatory training was made available to all staff to enable them to provide safe care and treatment to patients. Some of the training was completed through e-learning, which staff could access at a time to best suit their needs. Staff we spoke with told us that they were given time to complete training.
- Staff received annual mandatory training, which included key topics such as infection control, equality and diversity, fire safety, health and safety, moving and handling and medicine management.

- Staff training was co-ordinated and monitored by the ward manager and by a practice educator within the theatre department to ensure staff training was completed.
- Data provided by the trust showed that up to January 2017, 90% of Halton and CMTC theatres had received their mandatory training. Ward B4 and CMTC ward mandatory training compliance was 83% and 94%. The trust target was 85%.

Assessing and responding to patient risk

- Preoperative assessments were completed for each patient to ensure that they are fit to undergo an anaesthetic and therefore the planned surgical operation. The assessment was a clinical risk assessment that included for example, any communicable diseases, blood results, allergies, and in female patient of childbearing age, they were asked if they could be pregnant.
- We saw that patients with allergies wore coloured name bracelets to highlight to staff that the patient had an allergy.
- Staff we spoke with could identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing or medical emergencies.
- The trust used the National Early Warning Score system (NEWS). This is a national standardised approach to the detection of a deteriorating patient and has a clearly documented escalation response, in line with National Patient Safety Agency (NPSA) 2007 guidelines. On the NEWS chart, staff recorded observations including oxygen saturations, blood pressure and temperature and collated a total score. We saw that guidance was available on the NEWS charts to show what escalation was required for each trigger score.
- We reviewed 10 patients' NEWS charts and found that all observations had been completed appropriately and at the appropriate time required.
- We reviewed one patient record that had deteriorated on the ward. We saw that the appropriate scoring was included in the NEWS chart, the deterioration escalated to the medical team for review, and hourly observations started.
- A NEWS score audit had been carried out in December 2016 to January 2017, and the results showed an 86% compliance rate in NEWS recording across a sample of 80 patient records. This was above the 75% compliance rate target for the trust.
- A sepsis-screening tool was used to identify patients who were identified of potential sepsis. There were flow charts to support staff, with the procedures to follow, and patients were required to be immediately escalated to the medical team for review. Staff we spoke with on the wards reported they understood the escalation and guidelines to follow. Data provided by the trust showed that compliance with training in summoning emergency medical assistance on the surgical wards was consistently above the 85% trust target, ranging from 85% to 100%.
- The hospital used a care and comfort round form, to ensure their patients were safe and comfortable. The care and comfort round included assessing patient pain scores, nutrition, falls risk and NEWS score. The care and comfort rounds were undertaken at least every two hours for all patients to ensure patient safety. On the CMTC, observations were completed hourly for up to 12 hours following surgery to ensure patients were comfortable.
- If a patient's health deteriorated, staff were supported with medical input, and a resident medical officer (RMO) was available 24 hours per day seven days a week.
- We saw that a standard operating procedure was in place to support staff in the occurrence of a deteriorating patient. The procedure also included the arrangements to transfer the patient to the Warrington site. Data provided by the trust showed that from February 2016 to February 2017, 114 patients were transferred from Halton and CMTC, of which, 70 were from the surgical wards B4 and CMTC ward. This highlighted that staff monitored patients and made the necessary arrangements to ensure deteriorating patients received the right level of care.
- All patients were given a call bell so they were able to summon help in an emergency. We observed that patients on all wards we visited had call bells, and we saw these being used by patients to summon help from nursing staff.

- A theatre team brief was held before each theatre list started. This meeting highlighted all procedures that were being undertaken, and allowed staff to confirm that the appropriate equipment was available. We observed that the briefing was well attended by theatre staff.
- We observed the theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures. However, we saw on two occasions that the WHO checklist was not followed in full. We observed that in one surgical procedure no formal introduction of the team was completed in the time out section of the checklist. In another surgical procedure, the anaesthetist was not present for the identification check at the sign in section of the checklist. The WHO checklist is designed to eliminate the occurrence of surgical errors when followed correctly and requires all staff to take part. We raised this with the theatre manager at the time of inspection.
- A WHO audit was completed in July 2016. The data reviewed showed 100% compliance in 1251 patients across the Warrington and Halton sites.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that patients could receive safe care and treatment at all times, in line with relevant tools and guidance. The wards used an acuity tool to determine the numbers of staff that were required on a daily basis to provide safe care and treatment to patients. The staffing ratio of staff to patients on the CMTC ward was usually no more than one staff nurse to eight patients. The service provided three shifts; a long day, an early shift and a night shift to ensure adequate numbers of staff and continuity for patients. We saw that nurse staff numbers were displayed at the entrance to the ward so patients and visitors could see how many staff were on shift.
- We saw staffing in theatres met the Association for Perioperative Practice (AfPP) safe staffing guidelines. This ensured that there were adequately trained staff to provide safe surgical care to patients. We saw from the surgical procedures we attended that there were appropriate staffing levels for each theatre.
- In theatres and the ward, all registered nursing staff had completed immediate life support training and all senior nursing staff on the ward had completed advanced life support (ALS). This ensured that at least one member of staff on the ward was available on every shift with the necessary training to provide emergency life support. The ALS course teaches the knowledge and skills required to recognise and treat the deteriorating patient using a structured approach; deliver standardised CPR in adults; and manage a cardiac arrest by working with a multidisciplinary team in an emergency.
- In the recovery area at Halton hospital, we saw that there were no recovery staff on shift who were ALS trained. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines states that there should be at all times, at least one member of staff in recovery that is a certified ALS provider. We were informed that only two recovery staff had this qualification. However, they had all completed immediate life support training. Managers informed us that there were always staff on the department who had completed ALS training, and anaesthetists only left theatres once the patient had been transferred back to the ward so were available to deliver advanced life support. We saw evidence that there was an on-going programme of training to increase the number of ALS trained staff across Halton and CMTC, which included training band five registered nurses.
- The ward managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. The ward managers told us staffing levels were based on the numbers and dependency of patients and this was reviewed daily. Staffing levels on the wards were increased when necessary so patients needing 1:1 care could be appropriately supported. At the time of inspection we did not see any patients that required 1:1 support.
- All wards we visited had a number of staff vacancies. Data provided by the trust for January 2017 showed that the overall vacancy rate on the surgical wards B4 and CMTC ranged from 20% to 33%. Both wards had

approximately five nurse vacancies. Managers informed us that recruitment and retention of nurses was a priority, and the recruitment process was on going. the trust has introduced an electronic daily staffing review tool to ensure that the daily staffing level are visible trust wide.

- We saw that recruitment was taking place and senior nursing staff co-ordinated regular daily staffing meetings to cover staffing shortages.
- Matrons across the division met regularly to discuss shortfalls in staffing across the wards. An electronic daily staffing review tool was used to ensure that the daily staffing level were visible trust wide. This also enabled the senior on call team out of hours to see the staffing plan for each ward. Due to staffing shortfalls, staff were moved to other wards to be able to provide adequate cover on wards where staffing was insufficient. Staff we spoke with confirmed this.
- The ward managers told us they tried to use regular bank or agency staff and ensured temporary staff were accompanied by permanent trained staff where possible, so that patients received an appropriate level of care. Agency staff underwent induction and checks were carried out to ensure they had completed mandatory training prior to commencing employment. Nursing staff confirmed that they were often moved to wards to ensure agency staff worked alongside permanently employed staff to provide support and guidance.
- We saw that nursing staff reported incidents where they felt there was insufficient nursing staff on the ward. This showed a good culture of reporting low staffing levels to ensure quality and safety of the wards in which they worked.
- Nursing staff handovers occurred at every shift handover and included discussions about patient needs and any staffing or capacity issues.

Surgical staffing

- All treatment was consultant led at the hospital. Following surgery, the continued care of the patient remained the responsibility of the surgical consultant.
- The theatres had sufficient numbers of consultant surgeons and anaesthetists with the appropriate skill mix to complete the surgical theatre lists.
- Medical cover on ward B4 and the day case unit was provided by a ward-based doctor from Monday to Friday 8am to 7pm after which a handover was given to the Resident Medical Officer (RMO), who was available 24 hours a day over a seven day period.
- The hospital used an agency that provided a RMO on site 24 hours a day, seven days a week, on a rotational basis. This meant a doctor was on-site at all times of the day and night in the event of an emergency.
- At the time of the inspection, there were two Resident Medical Officers; one based in the CMTC, and the other at the main Halton hospital site. The RMO's were required to remain on site 24 hours a day.
- We saw that RMO's were provided with a handbook that gave them key information and telephone numbers.
- Senior on site medical support was available until 6pm.
- On-call senior medical support was available outside of core working hours. Nursing and medical staff confirmed that they were able to access senior medical support if required.
- We saw that daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Major incident awareness and training

- There was a documented major incident plan and business continuity plan for staff to follow in the event of a major incident.
- Managers informed us that the fire alarm was regularly tested and theatres had completed a fire drill.
- The trust had back-up generators for if the power supply failed. We were informed that these were regularly tested.
- There was a hospital-wide resuscitation team in place for dealing with medical emergencies. The team was led by the RMO and included senior nurses and supporting staff that were trained in advanced life support.

Surgery

Are surgery services effective?

Good

At the previous inspection in January 2015, we rated effective as good. Following this inspection we have maintained the overall rating because:

- Care and treatment was delivered to patients in line with the National Institute for Health and Care Excellence (NICE) guidelines.
- Pain scores were regularly recorded and patients informed us that they were offered appropriate pain relief.
- The Service participated in clinical audits through the advancing quality programme. The advancing quality programme aims to improve the quality of care patients receive in hospitals across the North West of England by measuring and reporting how well the hospitals are performing. Performance data in the April 2015 to March 2016 hip and knee audit showed excellent results across all six measures, ranging from 99% to 100%.
- We observed good multidisciplinary working with effective verbal and written communication between staff.

Evidence-based care and treatment

- Care and treatment was delivered to patients in line with the National Institute for Health and Care Excellence (NICE) guidelines. For example, the National Early Warning System (NEWS) was used to assess and respond to any change in a patients' condition. This was in-line with NICE guidance CG50. Staff also assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with venous thromboembolism: reducing the risk for patients in hospital NICE guidelines CG92.
- The hospital used care pathways that had been developed to meet best practice guidelines, which staff followed to ensure patients received safe care and treatment. We saw that on the CMTC ward, a patient assessment, care planning and risk assessments pathway was used to establish the needs and care required for each patient.
- In theatres, a perioperative care pathway was completed for all patients undergoing a surgical procedure. The pathway included the surgical safety checklist, preoperative site marking, baseline observations and a preoperative checklist.
- The surgical teams participated in clinical audits. Findings from clinical audits were reviewed at the monthly clinical audit meetings, divisional integrated governance group meetings, and any changes to guidance, and the impact that it would have on their practice was discussed. We saw from the meeting minutes that these meetings were attended by consultants and junior doctors to share learning.
- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We saw that policy and procedures were up to date and reviewed regularly.
- Discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation was avoided when making care and treatment decisions. A trust policy was in place regarding equality and discrimination. We observed staff to treat patients individually and without prejudice.
- The service contributed to national audits including Patient Reported Outcome Measures (PROMS). These audits were published nationally to provide evidence of outcomes of the service provided.
- We saw evidence of an audit programme that scheduled the audits to be completed for the year 2016. For example, we reviewed the audit programme for ophthalmology surgery and anaesthetics and found there a broad range of audits had taken place throughout the year.
- In theatres, a medical device implants register was kept to ensure there was a system to record all implants used and to report defects.
- Following day surgery, patients were provided with appropriate information and contact numbers in line with the Royal College of Surgeons (RCS) good surgical practice 2014.
- We saw that staff followed NICE guidelines QS86 following a patient fall that included checking for injury following a fall and medical examination following a fall.

- We saw that staff used anti-embolism stockings on patients following surgery to reduce the risk of them acquiring VTE. This was in line with NICE guidelines QS3 statement 5.
- We saw that the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance for day case/short stay surgery was followed, as patient social, medical and surgical factors were taken into consideration prior to surgery. For example, assessments were completed to ensure the patient was fit for surgery and we saw the early mobilisation of patients following surgery to enable patients to return home with a reduced length of stay in hospital.

Pain relief

- Pain scores were recorded as part of the NEWS. We saw that pain scores were documented and that pain relief was given to patients at the specified times. We reviewed seven patient records and found pain had been recorded appropriately in all records.
- We saw that pain scores were recorded by nursing staff as part of the two hourly care and comfort rounds. The care and comfort round was used to ensure that patients were checked on a regular basis and that their needs had been met. On the CMTC ward, observations were completed hourly for at least the first 12 hours to ensure patients were comfortable and pain was suitably managed.
- A team of acute pain specialist nurses that worked across both hospitals supported staff on the surgical wards and theatres. Ward staff reported that if a patient was experiencing pain they would escalate their concern to the medical team and refer to the specialist pain team for symptom control.
- All patients we spoke with told us that they thought their pain was well managed.
- Patient records showed that patients received the required pain relief, and recorded during every care and comfort round.

Nutrition and hydration

- We reviewed seven patient records and found that Malnutrition Universal Screening Tool (MUST) scores had been recorded appropriately. The MUST score is a five-step screening tool to identify adults who are at risk of malnutrition.
- Staff followed guidance on fasting prior to surgery, which was based on the recommendations of the Royal College of Anaesthetists, (RCA) which states that food can be eaten up to six hours, and clear fluids can be consumed up to two hours before surgery. We saw that as part of the perioperative pathway, ward staff attended the theatre to provide a handover of patients, which included hand over of starve times.
- Most patients we spoke with reported that they enjoyed the food at the hospital.
- Patient records included assessments of patients' nutritional requirements and any allergies or food intolerances.
- Patients who required support and assistance with eating and drinking were identified using a coloured jug system and supported by staff accordingly.
- A dietetic service was available for those patients who required specialist dietary support.
- Patient Led Assessments of the Care Environment (PLACE) showed that 84% of patients thought that the food was good at the hospital. This was below the national average of 88%. However, our feedback from patients reported that the food was good.

Patient outcomes

- Information about the outcomes of patients' care and treatment was collected and monitored by the trust. Managers we spoke with were aware of their responsibilities to collect and disseminate the findings. We saw from clinical audit meeting minutes that audit data was shared, and outcomes for patients discussed.
- The Service participated in clinical audits through the advancing quality programme. The advancing quality programme aims to improve the quality of care patients receive in hospitals across the North West of England by measuring and reporting how well the hospitals are performing. Performance data in the April 2015 to March 2016 hip and knee audit showed excellent results across

all six measures, ranging from 99% to 100%. The measures included appropriate antibiotics given one hour before surgery and VTE medication given for the right amount of time after surgery.

- The service participated in a full range of national audits to measure outcomes for the local population against the England average. The outcomes for patients were used to ensure that the services offered provided patients high quality, safe services at the trust.
- From the April 2015 to March 2016, Patient Reporting Outcomes Measures (PROMS), hip replacement (EQ VAS), knee replacement (EQ VAS and EQ-5D index) and varicose vein (EQ-5D index) indicators showed more patients' health improving and fewer patients' health worsening than the England average.
- In the 2016, hip fracture audit; the risk adjusted 30 day mortality rate was 6.4% which was within the expected range and was an improvement over the 2015 audit at 7.1%. The percentage of patients having surgery on the day or day after admission, the perioperative surgical assessment rate and the proportion of patients developing pressure sores did not meet the national standards. However, the trust had seen some improvement over their 2015 results.
- In the national bowel cancer audit, the trust was in expected range for the risk adjusted 90 day post-operative mortality rate, the risk adjusted two year post-operative mortality rate, the risk adjusted 90 day unplanned readmission rate and the risk adjusted 18 month stoma rate. However, 72% of patients undergoing a major resection had a longer length of stay than the national aggregate. This performance was an improvement over the 2014 data.
- Between September and October 2015, patients' relative risk of readmission for non-elective surgery was similar to the England average.
- The trust measured the number of patients that returned to hospital within 30 days following discharge from hospital. Data from 2015 to November 2016, showed trauma and orthopaedic, 30 day readmission rates for the Halton site were generally within range (74 readmissions against an expected 65) and in urology, there were 113 readmissions against an expected 109.

Competent staff

- Staff were able to access training both internally and externally. There was an online learning system across the trust where staff could access training. All staff we spoke with reported that they were encouraged and able to access training to improve their skills and knowledge.
- In theatres, a practice educator monitored training compliance across the department and supported the development of staff through teaching and organising training.
- All qualified nurses who worked within theatres or the ward for six months or more had recorded validation of professional registration. This meant the hospital conducted annual checks to make sure all the nurses are registered with the Nursing and Midwifery Council (NMC) and is considered good practice. We saw that a nursing staff validation report highlighted those staff that needed to revalidate within the next six months.
- Appraisal rates were variable across the surgical specialties and theatres. Data provided by the trust for January 2017, showed that that the numbers of nursing and medical staff receiving an appraisal ranged from 71% to 95%. The trust target was 85%.
- The nursing and junior medical staff spoke positively about their learning and development opportunities and told us they were well supported by their line manager.
- Additional role specific training was provided to staff based upon their clinical practice. This included summoning emergency medical assistance. Compliance with this training across the division was consistently above the 85% trust target, ranging from 85% to 89%.
- There was a cardiac arrest team based within the hospital to provide support in the event of a medical emergency. The resident medical officers and senior nurse on-site were available 24 hours a day to provide assistance in the event of a respiratory or cardio-respiratory arrest or imminent event.
- The trust employed RMO's through an agency. The agency was responsible in ensuring that the employed RMO's had the necessary training to complete their role. Information provided by the hospital showed that the RMO's were trained in advanced life support (ALS).

- All wards we visited reported that they had good support from the RMO and reacted quickly if they were needed.

Multidisciplinary working

- We observed good multidisciplinary working with effective verbal and written communication between staff. Staff confirmed that there were good working relationships between staff that included physiotherapists, nurses, and consultants.
- We saw that the therapy team worked closely with the ward staff to ensure that patients were seen quickly following surgery to further enhance their discharge.
- We observed nurses working alongside consultants. Interactions were positive and professional.
- We observed a theatre briefing and saw that it was well attended by all levels of staff.
- We observed positive working relationships between managers and the staff groups. We observed managers across the department to have close professional relationships with the staffing groups and provided them with advice and guidance as required. In theatres, we saw senior staff provided mentorship for junior members and students.
- Ward staff liaised with a number of different services when co-ordinating a patient discharge. This included hospitals, community services, and social services depending on where the patient lived.
- Staff handover meetings took place during shift changes and safety briefings were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns. The RMO confirmed that they received a daily handover.
- Patient records showed there was routine input from nursing and medical staff and allied health professionals.

Seven-day services

- Theatres were scheduled to operate between Monday and Friday on a weekly basis.
- Consultants and anaesthetists responsible for delivering treatment were on-call 24 hours a day. Staff informed us that they were aware of the on-call arrangements and we saw evidence of the on-call rota.
- The day case unit operated during normal week day hours and was not open overnight or at weekends.
- Deteriorating patients were transferred to the Warrington site if they required stabilisation or emergency surgery.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends.
- Two RMO's remained on site 24 hours per day seven days per week to be able to review patients and respond to a medical emergency.

Access to information

- The theatres department used an electronic system to capture information about patient scheduling and theatre performance.
- Computers were available in the wards and theatre areas. All staff had secure, personal log in details and had access to e-mail and all hospital systems. We observed that no computer terminals were left unattended displaying confidential information.
- All staff had access to the trust's policy and procedures via the intranet to support and guide professional practice.
- All relevant staff had access to patient records electronically or paper based to enable a complete and contemporaneous record of patients care and treatment.
- Discharge summaries were sent to GPs on discharge to ensure continuity of care within the community. We saw evidence that when a patient was discharged from hospital they were given a copy of their discharge form and a copy was forwarded to the GP. We saw that discharge summaries included the type of surgical procedure and medication prescribed.
- The consultant and nurses names were on boards above the patients beds so that patients and their relatives knew who was responsible for their care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a current policy for consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This was available for staff on the intranet.
- Staff were able to demonstrate their knowledge of consent and mental capacity and told us if there were concerns over a patient's capacity to consent, they would seek further advice and assistance.
- A trust-wide safeguarding team provided support and guidance for staff for mental capacity assessments, best interest meetings and deprivation of liberty safeguards applications. All staff we spoke with reported they could access the safeguarding team for advice and guidance if required.
- From the records we reviewed, and our observations of surgical procedures, we saw that consent was obtained prior to treatment.
- We did not see any patients that required a capacity or best interests meeting. Staff informed us that this was due to the generally lower acuity of patients seen at the hospital.
- The senior management team completed a consent audit in January 2017. The audit focussed on the two-stage consent process. Stage 1 is the provision of information, discussion of options and initial (oral) decision with the patient. At this stage, patient information leaflets should be given to the patient and documented. The patient signs the top white copy indicating they have received the information; and the yellow copy is given to the patient. Stage 2 is confirmation that the patient wishes to go ahead with the procedure and signs the documents and the yellow copy is given to the patient.
- The audit found the trust to be 86% compliant with the use of the two-stage consent form. Areas of improvement were recorded on an action plan, which included to ensure patients are given a copy of the consent form and document the information and leaflets given to patients. Staff we spoke with were aware of these actions and we saw that information provided was documented in patient records.

Are surgery services caring?

Good

At the previous inspection in January 2015, we rated caring as good. Following this inspection we have maintained the overall rating because:

- All patients and relatives we spoke with told us that that all members of staff treated them with dignity and respect.
- We observed many positive interactions between staff and patients during our inspection. We saw that staff were professional and friendly and created a relaxed friendly environment.
- Patients we spoke with were very positive about the way staff treated them.
- Patients and those close to them told us that they were involved in planning and making decisions about their care and treatment.

Compassionate care

- We spoke with 15 patients and relatives who all told us that that they were treated with dignity and respect by all members of staff. Patients told us they found the staff polite, friendly and approachable. Comments included. 'Couldn't be better', 'nothing is too much trouble' and the 'standards here are excellent, it's the best hospital I've ever been in'.
- We observed staff greeting patients and relatives. Staff were polite friendly and helpful in their approach.
- Staff demonstrated flexibility and kindness when meeting people's wishes. Staff were able to tell us that for a patient who had a terminally ill partner in Warrington Hospital, they arranged for them to be together at the Halton site. Beds were moved into a side room so they could be together and arrangements made to provide the necessary medical support.
- We reviewed approximately 60 thank you cards on the ward. All cards provided an insight into the care received at the hospital. Many of the cards thanked all the nursing staff for all they had done and the exemplary care they had received. Comments included 'thank you for your kindness, tenderness and smiling faces' and thank you for your 'lovely, caring and calming

confidence'. We observed throughout the inspection that the environment was relaxed, and the nursing and medical team approached patients, smiling and treated patients with kindness and compassion.

- We observed that staff respected patient confidentiality and ensured sensitive discussions took place in privacy. All patients we asked reported their dignity and privacy was maintained throughout their hospital stay.
- Staff made sure that patients' privacy and dignity was respected, including during intimate care. We saw that patients on the ward had the curtains pulled around to maintain their dignity during examination.
- We saw that the theatre nurses spoke calmly to patients and introduced themselves to reassure the patients following a surgical procedure.
- Patient led assessments of the care environment (PLACE) showed that 79% of patients thought that their privacy and dignity had been maintained during their time at the hospital. This was below the national average of 84%. However, our observations and patient feedback highlighted that privacy and dignity was being maintained.
- Staff supported patients to be mobile and independent postoperatively. We saw that Physiotherapists encouraged patients to mobilise soon after surgery and promoted independence. Patients informed us that they were seen quickly after surgery and rehabilitation started soon after surgery.
- We observed many positive interactions between staff and patients during out inspection. We saw that staff were professional and friendly and created a relaxed friendly environment. Patients confirmed that nurses that were compassionate and caring treated them.
- In the NHS England Friends and Family Test (FFT) between December 2015 to November 2016, the trust scored about the same as the England average for the percentage of people who would recommend the trust to family and friends.
- The wards displayed their friends and family test scores each month to highlight their achievements. We reviewed the November 2016, FFT scores for ward B4, and the day case treatment centre and scores were 98% and 100%. This confirmed that patients rated the service highly.

Understanding and involvement of patients and those close to them

- We saw that staff communicated with patients so that they understood their care, treatment and condition. Patients confirmed that staff explained their care and treatment and kept them up to date with any required information.
- Patients and families were encouraged to participate through feedback and surveys. This showed that they cared about 'getting it right' for the patients.
- Patients and those close to them told us, that they were involved in planning and making decisions about their care and treatment.
- Visiting times were flexible on the ward to take into account the needs of the patient's relatives. Wards had visiting from 12pm until 8pm to ensure relatives could visit. Ward staff informed us that visiting times could be altered to allow flexibility for families if needed.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment. This was highlighted in the preoperative assessment so reasonable adjustments could be made. For example, an individual room could be made available for those patients living with dementia so that relatives could stay and provide support.
- We were informed one member of staff on the ward endeavoured to source particular foods from various supermarkets for a patient with special dietary needs. The ward manager informed us that they try to understand and cater for everyone's needs to ensure every patient stay is a positive experience.
- We observed that information was available to patients about who to contact if they had any concerns about their care. Additionally there was a wide variety of information leaflets available in all areas of the hospital to help support patients with particular problems or to offer advice.

Emotional support

- We saw from records and our observations that staff completed regular observational checks of patients in their care, to ensure that they were comfortable, and to answer any questions they may have.

Surgery

- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly and in a way they could understand.
- Throughout our visit we observed staff giving reassurance to patients, with additional support given when it was required, especially if patients were apprehensive or anxious.
- Counselling services were available to those that needed psychological support.
- For those patients that were at the end of life, a palliative care team offered practical and emotional support to patients and their families.

Are surgery services responsive?

Good

At the previous inspection in January 2015, we rated responsive as good. Following this inspection we have maintained the overall rating because:

- A variety of surgical procedures were available within the service, including orthopaedics and urology surgery to meet the needs of the local population.
- Data provided by the trust showed that bed occupancy rates between December 2016 to February 2017 on Halton and CMTC surgical wards were low, ranging from 21% to 27% and 37% to 52%. This meant that there were enough bed spaces for patients on a monthly basis for patients attending for surgery.
- The average length of stay for surgical elective patients was better at the trust at 2.7 days, compared to 3.3 days for the England average.
- The trust monitored the number of cancelled operations on the day of surgery. Performance data provided by the trust showed that the average number of cancelled operations at the Halton site from February 2016 to January 2017 was low at 9.3% and at CMTC, 5.7%.
- From April 2016 to February 2017, the division reported they received only 28 complaints at the Halton sites. The in-patient surgical wards B4 only received three complaints and CMTC ward only received three complaints within that period.
- The trust's referral to treatment time (RTT) for the percentage of patients seen within 18 weeks was 76%, which was better than the England average of 71%.

Service planning and delivery to meet the needs of local people

- The services provided at the hospital reflected the needs of the population they served, and they ensured flexibility, choice and continuity of care. A variety of surgical procedures including day case and in-patient surgery was available within the service, including orthopaedics and urology surgery. The procedures carried out were determined in conjunction with the local clinical commissioning groups to serve the local population.
- There were arrangements in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the hospital, such as vascular surgery.
- As part of the preoperative assessment process, patients with lower risk medical conditions could elect to have surgery at the Halton site. This helped the service plan care and treatment for patients ensuring waiting times were kept to a minimum.
- For elective patients that were assessed as higher risk, surgery was arranged at the Warrington site.
- There was no emergency surgery at the Halton site, so any patients that required emergency surgery or those patients with a deteriorating condition could be transferred to the Warrington site.
- Surgical lists were planned four weeks in advance to provide patients with enough time to organise their admission to hospital.

Access and flow

- Patients were admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via GP referral.
- 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. By staggering admission times, the hospital was able to

ensure those patients with the most urgent needs were prioritised. For example, patients with diabetes were placed at the beginning of the theatre lists so that they had their surgery as quickly as possible.

- During our inspection, the theatre lists generally ran on time. We were told that lists usually ran on time, as they did not have the same bed pressures as the Warrington site.
- Data provided by the trust showed that bed occupancy rates from December 2016 to February 2017 for ward B4 and CMTC ward were low ranging from 21% to 27% and 37% to 52%. This meant that there were enough bed spaces for patients on a monthly basis for patients attending for surgery.
- The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Between October 2015 and November 2016, the average length of stay for surgical elective patients was better at the trust at 2.7 days, compared to 3.3 days for the England average.
- Halton hospital had a shorter length of stay across both elective and non-elective admissions than both the trust and the England average.
- Between December 2015 and November 2016, the trust's overall referral to treatment time (RTT) for the percentage of patients seen within 18 weeks was 76.9%, which was better than the England average of 71.5%. The trust was consistently above the England average for the whole period. However, RTT performance for urology, general surgery and ear, nose and throat (ENT) were marginally below the England average.
- The trust monitored the number of cancelled operations on the day of surgery. Performance data provided by the trust showed that the average number of cancelled operations at the Halton site from February 2016 to January 2017 was 9.3% and at CMTC, 5.7%. Reasons for cancellation included the patient not being fit for surgery and staffing sickness.
- At the time of the inspection, we were informed that there were no medical outliers on the wards. Medical outliers are medical patients receiving care and treatment on surgical wards that did not necessarily specialise in the care they required.
- Data provided by the trust showed that between September 2016 to December 2016 there were no medical outliers on surgical wards B4 or CMTC ward. We were informed that although they did not have any medical outliers, there were times when B4 closed at a weekend that the surgical patients would be transferred to CMTC surgical ward.
- The trust monitored the number of delayed discharges across the surgical wards. From August 2016 to January 2017, the trust reported there had been 165 patients on surgical wards that were medically fit to leave but were not able to. The main reason for delays in patients being discharged was due to waiting for further non-acute NHS care such as rehabilitation or patient or family choice of care setting. The surgical inpatient wards at Halton and CMTC reported they did not experience the same bed pressures as the Warrington site and although patient delays did occur, due to the lower level needs of the patients receiving surgery, they had fewer delayed discharges. There were no delayed discharges reported during the inspection.
- There was 24-hour medical cover on site to attend to patients who had deteriorating needs.
- We saw there was a medical emergencies plan for deteriorating patients to transfer to Warrington hospital for stabilisation or unplanned emergency surgery.
- From February 2016 to February 2017, data provided by the trust showed 125 patients transferred from Halton hospital to Warrington hospital. Of these, 114 were deemed deteriorating patients which was 1.1% of patients, which is low compared to the number of surgical procedures undertaken (9637) in that period.

Meeting people's individual needs

- Services were planned and delivered to take account of the needs of different people. Individual needs were considered at preoperative assessments to ensure their needs could be met prior to surgery. This included allergies and pre-existing conditions.
- Surgery at Halton and CMTC was carefully planned to ensure only those patients who had lower level needs received surgery at that site. This was due to not having emergency theatres 24 hours per day, and lower levels of medical cover.

- All areas of the ward were wheelchair accessible, and all inpatient side rooms and shared bathrooms had level access showering facilities.
- There were a number of specialist nurses within the trust to help support the care and treatment of patients. These nurses specialised in a specific area. For example, there were palliative care nurses, diabetes nurses and psychiatric nurses to support patients with mental health needs.
- There were a number of link nurses to help support patients on the ward. These link nurses were trained and had a special interest in a specific area. For example, there were link nurses on the inpatient ward for dementia and diabetes.
- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- There was an interpreter service available for patients for whom English was not their first language. Staff were aware of the service and how to access it.
- Staff used a 'this is me' document for patients admitted to the hospital with dementia. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes. We saw evidence of this in the patient records we looked at.
- A discreet symbol was used on the ward whiteboards to highlight any additional needs of patients and coloured wristbands were used to denote allergies. We saw that patients with additional needs were discussed at the team safety briefs that included any safeguarding concerns.
- Staff could access appropriate equipment such as specialist commodes, larger beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.
- Adapted cutlery was available for those patients with hand motor skills difficulties to aid their independence.
- Wards provided individual side rooms for patients with communicable diseases to minimise the spread of infection.
- Although there was not a learning disability lead nurse within the trust, ward staff referred patients to the safeguarding team to flag the admission to hospital. Staff informed us that often they were able to provide an individual room and provide access to allow family or carers to stay overnight to support their individual needs. This service was also available for patients with mental health needs and those patients living with dementia.

Learning from complaints and concerns

- The chief executive was the person responsible for all complaints in the trust, and was delegated to the patient experience team under the leadership of the deputy director of governance and quality.
- The wards had information leaflets for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS).
- From April 2016 to February 2017, the surgery, women's and children (SWC) division reported they had received only 28 complaints at the Halton sites. Wards B4 only received three complaints and CMTC ward only received three complaints within that period. Low levels of complaints and high patient satisfaction showed that the surgical wards were being responsive and caring to the needs of the patients.
- The patients we spoke with were aware of the process for raising their concerns with the trust.
- Notice boards outside the ward included information such as the number of complaints received during the month.
- Managers informed us that they endeavoured to resolve complaints quickly at ward level and met with patients and their families to rectify any concerns they had immediately.

Are surgery services well-led?

Good

At the previous inspection in January 2015, we rated well led as good. Following this inspection we have maintained the overall rating because:

- Senior managers were clear on their strategy to provide high quality services for patients, which included working collaborative within the organisation, and in partnership with other trusts to deliver high quality services.
- There was a clear governance structure to support governance and risk management and staff had clearly defined roles, responsibilities and reporting structure.
- On the wards and theatres, there were daily briefings to discuss day-to-day issues, share information regarding incidents and risk areas, to increase staff awareness and avoid reoccurrence.
- We saw that Local Invasive Standards for Invasive Procedures (LocSSIP's) had been developed in partnership with the North West theatre network. The standards were in place to ensure high quality, safe care and treatment for all patients.
- All staff we spoke with were positive about their relationships with their immediate managers. Staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to.
- Staff told us, and we observed that there was a friendly and open culture within the trust. Many staff had worked there many years and progressed through training opportunities.
- Staff in theatres reported that they were a close team that worked well together and felt able to challenge poor practice.

However:

- Although there were formal audits completed, that included infection control. We saw no evidence that managers had a formal system or process of oversight, that ensured the cleanliness of equipment, and system checks were maintained. However, during the unannounced inspection we saw that the service managers had reacted quickly to our concerns, and new systems and processes implemented with management oversight, to ensure compliance with standards and policy.

Leadership of service

- The senior managers had the skills, knowledge, experience and integrity that they needed to lead effectively. The new divisional structure was embedded and led by a senior management team and were aware of their current performance and direction of the trust.
- Ward managers, overseen by matrons, led the surgical wards and there were theatre co-ordinators and a theatres manager in place to oversee the day-to-day running of theatre services.
- Theatres and ward-based staff told us they clearly understood the reporting structures and they received good support from their immediate line managers.

Vision and strategy for this service

- The hospital had a clear mission, vision and strategy, which was to provide high quality, safe integrated healthcare for all patients. We found the hospital strategic direction was well described by the senior management team and were focused on quality of services, the people delivering them, and the sustainability of the service through the financial pressures the trust faced. We saw that the vision and values of the trust were posted on the walls around the hospital.
- Senior managers were clear on their five-year plan, which included a cost improvement programme, working collaboratively within the organisation, and in partnership with other trusts to deliver high quality services.
- Most staff we spoke with were clear on the direction of their service and the financial pressures the trust faced.
- A new divisional and clinical business unit structure had been developed in 2015. The new structure created two divisions and eight clinical business units (CBU's) to oversee clinical and business activity. The CBU's were led by clinicians, managers and senior nurses to provide a robust clinical, operational and nursing alignment. Managers informed us that this provided a better balance and involvement in relation to the direction of the service.

Governance, risk management and quality measurement

Surgery

- There was a clear governance structure to support governance and risk management and staff had clearly defined roles, responsibilities and reporting structure. At ward level, staff reported they were aware of the reporting structure.
- Senior managers, nurses and clinicians were clear on the risks associated to their division. These included balancing finances with quality, ensuring they met the cost improvement programme target, and staffing shortages across the division.
- Managers reported that quality impact assessments were completed and approved by the board prior to any cost improvement plan being introduced, and there was support from a transformation team pre and post changes to monitor and evidence the quality of any changes.
- There was a clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. We reviewed that there were action plans in place to address the identified risks.
- We reviewed the divisional risk registers and saw that key risks had been identified and assessed with review dates specified.
- On the wards and theatres, we saw there were daily briefings to discuss day-to-day issues and to share information on incidents and risk areas.
- All managers across both operating sites highlighted they had monthly managers meetings to discuss performance of the division and share knowledge and experience.
- We saw that the monitoring of audits took place monthly, and there was a clinical audit meeting to discuss findings and results.
- We saw that Local Invasive Standards for Invasive Procedures (LocSSIP's) had been developed in partnership with the North West theatre network. We saw that these procedures included a standard for the safety briefing prior to commencement of an operating theatre list and the WHO checklist. The operating standards gave step-by-step instructions to follow to eliminate any surgical errors.
- Although, there were safety standards in place to eliminate errors in surgical procedures, the trust had two never events in March 2017 at the Halton site. These were currently under investigation by the trust as to the cause of the errors.
- We saw that the service leaders had taken immediate action to ascertain the reasons for the never events with extra support, training and guidance given to all staff to ensure future compliance with the surgical safety procedures. From discussions with managers and staff, the service had taken appropriate action to ensure future compliance. This included 1:1 sessions with staff to go through the standard procedures, human factors training, manager observations of the WHO checklist being performed, and changes to the debrief checklist which included 'what went well' and 'what can be done better'.
- Although there were formal audits completed that included infection control. We saw no evidence that senior managers had a formal system or process, that the cleanliness of equipment and system checks were maintained to ensure safe care and treatment for patients. However, during the unannounced inspection we saw that the service managers had reacted quickly to our concerns, and new systems and processes implemented with management oversight to ensure compliance with standards and policy.
- Performance information was relayed to wards through performance dashboards. The dashboards provided senior nurses with information regarding workforce statistics such as budget expenditure, workforce profile, recruitment and staff sickness. Although the dashboards provided good information about the workforce they did however, lack any patient centred measures. For example, VTE assessment compliance, infection control compliance, incidents and falls. The focus of a dashboard is to engage staff, empowering them to improve quality of patient care by being able to monitor performance and compliance using the dashboard over a specified period.

Culture within the service

- All staff we spoke with were positive about their relationships with their immediate managers. Staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to.

- Staff at all levels were aware of the duty of candour in regards to being open and honest with patients, and we saw that open and honest letters were sent to patients following complaints or incidents.
- We saw that a full range of incidents were reported using the trust electronic system and staff told us that they were encouraged to report incidents so that lessons could be learnt.
- Staff told us that there was a friendly and open culture within the trust, and many staff had worked there many years and progressed through training opportunities.
- Staff in theatres reported that they were a close team that worked well together and felt able to challenge poor practice.
- In the NHS staff survey 2016, the percentage of staff both white and black and minority ethnic (BME) groups who reported experiencing bullying from staff in the last 12 months was 18% and 22%. This was below the average median for acute trusts.
- The survey also reported that 93% of both white and BME groups believed the organisation provided equal opportunities for career progression or promotion. This was significantly better than the average median for trusts.

Public engagement and staff engagement

- Trust board meeting minutes and papers were available to the public online, which helped them understand more about the hospital and how it was performing.
- The trust had news releases on its website pages to keep members of the local community up to date with current events. We observed that the news releases on the website were current and up to date.
- The trust had Facebook and Twitter accounts to share information with patients and receive feedback. We saw that information was given with regards stopping smoking, and provided information on their latest drop in session.
- The hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. The friends and family test showed the percentage of patients and families that would recommend the service. We saw that all surgical wards displayed this information at the ward entrances.
- The trust's friends and family test performance measured the percentage of people who were likely to recommend the trust to friends and family. Results showed between December 2015 to November 2016, scores were generally about the same as the England average.
- Information on the number of incidents, complaints and general information for the general public was displayed using notice boards on the ward and theatre areas we inspected.
- The trust participated in the NHS staff survey to gather their views. The survey asks 34 questions and the results analysed and compared with other trusts across England. The results from the 2016 NHS staff survey showed that the trust performed better than other trusts in 10 questions, about the same in 17 questions, and worse in seven questions. Areas that the trust performed better included, staff satisfaction with their level of responsibility and involvement, and support from their immediate managers. Areas where the trust scored worse included the quality of non-mandatory training and the response rate from staff to the survey (33%). The England average was 41%.
- The trust carried out a divisional temperature check audit during 2016 in which staff were asked eight questions in relation to the service. This included how likely they were to recommend the trust as a place to work. We reviewed the data provided by the trust for specialist surgery. The data showed that 96% of staff felt they had been treated fairly and consistently in the last month, however only 71% of staff would recommend the trust as a place to work.

Innovation, improvement and sustainability

- We saw that leaders and staff strived for continuous learning, improvement and innovation. Managers were sited on the current clinical and financial pressures, and looked for ways to develop effective clinical networking and integrated partnerships with other trust services. For example, in theatres we saw that local safety procedures for invasive procedures had been developed by working within a North West collaborative.

Surgery

- In Ophthalmology, they had commenced cataract surgery under local anaesthetics and eye stents in glaucoma surgery, improving efficiencies and patient experience.
- The trust was rated as one of the best in the North West by the Advancing Quality Alliance (AQuA) for providing hip and knee replacement care, with a score of 97.7%.
- A patient safety initiative had been implemeted in orthopaedics. The service had introduced a 'Red Cast', which was a red band around the cast to visually highlight that extra care needed to be taken with the patient, remind staff to frequently change their position, and encourage patients to be mobile to relieve pressure on the cast.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Between October 2015 and September 2016 Halton General Hospital provided 118,450 outpatient appointments.

The trust provided outpatient clinics for all specialties and diagnostic (scanning) services at Warrington and Halton Hospitals so people could access their initial appointments close to home wherever possible. The trust also provided some outpatient services in the local community. Warrington & Halton hospitals main outpatient clinics hosted over 300 clinics per week, which included 65 ophthalmology and 51 trauma and orthopaedic clinics.

The main outpatient clinic at Halton hospital was located near the main entrance of the hospital and consisted of four clinical areas, each with small waiting areas that hosted 19 consultation rooms in total. Some specialities had dedicated outpatient areas including ophthalmology, breast screening, physiotherapy and diabetes clinics.

Diagnostic Imaging sat within the Diagnostic CBU in Acute Care Services along with Pathology and Cardio-Respiratory services. The Trust provided imaging in various modalities for both inpatients and outpatients, magnetic resonance imaging (MRI), computerised tomography (CT), X-ray/ Primary Imaging, Nuclear Medicine, DEXA, Ultrasound and Interventional Radiology. The Trust also led on the outpatient Breast Screening service across the Warrington, Halton, St Helen's and Knowsley area.

During the inspection we spoke to 48 staff, 35 patients and their relatives. At Halton we reviewed 14 sets of patients' healthcare records, 10 x-ray case records and 10 x-ray films.

We visited Halton hospital and Cheshire and Merseyside Treatment Centre, X-ray, Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), Ultrasound, general Outpatients Ophthalmology, Audiology, Physiotherapy, ECG/Physiology, Phlebotomy, Cardiac, Rheumatology, Ear Nose and Throat, Orthoptics and Medical Records.

Outpatients and diagnostic imaging

Summary of findings

We rated this service as requires improvement because:

- Staff identified, recorded and managed safety incidents inconsistently. They had failed to report three serious incidents and had breached radiation regulations.
- We found breaches of Ionising Radiation Regulations 99, regulation 32, which refers to routine quality assurance of equipment used in diagnostic imaging.
- A Computed Radiography reader in a corridor presented a risk of radiation exposure and staff did not record checks of emergency resuscitation equipment consistently.
- Staff did not record cleaning adequately in some departments and they did not always comply with cleaning and infection control procedures to prevent risk to patients, staff and visitors.
- Large machines were stored in hospital corridors and clinic rooms were full with equipment that presented a potential hazard.
- Outpatients and diagnostics were established as a stand-alone Clinical Business Unit (CBU) and staff voiced concerns about the lack of clear leadership structure. Staff voiced their concerns regarding a lack of on site management for radiography staff at Halton.
- Whilst records we reviewed confirmed that risk registers and some risk action plans were in place, we saw no evidence that these were being managed effectively.
- There had been significant changes in the leadership team which had the left the staff feeling disconnected and unsure of the strategy and future vision of the service.

However:

- Staff had mandatory training in line with the trust target of 85% completion.
- Staff provided patients' treatment and care in line with evidence- based guidelines and best practice.
- The service audited practice well to maintain standards. Radiography staff had received and award for a research paper from the UK Research Council.
- All clinical staff could access patients' electronic records securely from any terminal.
- Staff followed appropriate procedures for obtaining and documenting consent.
- Staff were caring and showed understanding in communicating with patients. Administrative, nursing and medical staff took care to show their patients respect and protect their dignity. Patients consistently gave positive feedback about staff.
- The service monitored referral to treatment times continually. Times were consistently better than the England average, except for urology, ophthalmology and paediatric orthopaedics. Waiting times for referral and treatment for cancer were better than the England average.
- Staff in general felt supported by managers and there was an open culture of working together. Many staff expressed positive views about leadership from the new outpatient matron.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

- Quality assurance processes for radiology equipment were poorly maintained, with several breaches of Ionising Radiations Regulations 1999 (IRR99).
- Quality Assurance checks for the theatre image intensifier and Image intensifiers in CMTC rooms one and two had dates missing for checks in March 2016, July 2016, October and November 2016.
- A Computed Radiography reader in a corridor presented a risk of radiation exposure and staff did not record checks of emergency resuscitation equipment consistently.
- Cleaning records were not maintained in outpatient treatment areas, with clinic rooms used as both consultation rooms and treatment rooms without being cleaned after individual patient use.
- Infection control measures were inconsistent, we observed staff not using hand gel in between patients or cleaning treatment couches after each patient use in some areas.
- Large pieces of equipment were stored in corridors and treatment rooms were crammed with equipment, limiting access and creating moving and handling difficulties for staff.
- We saw variable practice in the standard of record keeping, with clinical notes clearly ordered and maintained in some cases, whilst others had gaps in information about patient follow up which may have caused a risk to patient safety and care.
- Patients attended the phlebotomy clinic for blood tests. The clinic had two specialist phlebotomy chairs, however one of these had cracked arm rests. Staff advised new arm rests had been ordered in January 2017. We also noted that the other chair had a torn seat; records confirmed that this had been documented on the cleaning sheet in January 2017.
- Outpatient areas where children attended appointments were not child-friendly. We noted that the outpatient departments at Halton hospital were more limited generally, due to the age and layout of the facilities.

However:

- The department had improved levels of mandatory training to meet the trust target of 85% completion.
- Staff had good awareness of safeguarding and effective processes were in place for this.
- Radiation Protection Supervisors were in all clinical areas where this was required.

Incidents

- Managers at the Cheshire and Merseyside Treatment centre (CMTC) advised the highest report of incidents was for patients attending the wrong clinics, due to inadequate signage for departments. None of the staff we spoke with were able to tell us of any follow up actions in response to this. The trust identified that as the treatment centre is in a new building and out patients department is located at the front of the building it is not clear how patients could get lost due to signage.
- In accordance with the Serious Incident Framework 2015, the trust reported one serious incident in diagnostic imaging and two in outpatients between January 2016 and December 2016.
- Incidents were reported by staff using an electronic reporting system. Staff we spoke with understood their responsibility to report incidents and could give examples of when they had done this. Incidents were reported to the matron each month for review at divisional meetings.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systematic barriers area available at a national level, and should have been implemented by all healthcare providers. Between January 2016 and December 2016, the trust reported no incidents which were classified as Never Events for Outpatients.

Outpatients and diagnostic imaging

- Staff in outpatients advised a common theme identified in incident reports was concerning patient falls. However none of the staff we spoke with could tell us if any actions had been put in place to try and prevent falls in the future.
- In diagnostics, we were informed of four level one incidents that had been investigated in 2016. Level one incidents are those which result in a need for further intervention or treatment, or permanent harm. Three incidences related to missed diagnoses occurring in previous years and a further incident relating to a patient fall during an x-ray. Each incident had undergone investigation, analysis, and conclusions made.
- Learning from incidents was shared at monthly team meetings, in staff emails and on staff communication notice boards in staff room areas. We observed records of sign in sheets kept by local managers, which confirmed staff had read this information.
- Staff understood their responsibilities to raise concerns and near misses and nurses, allied health professionals (AHP) and administration staff were able to tell us what sort of incident should be reported and what the reporting process was.

Cleanliness, infection control and hygiene

- The trust had a policy for infection prevention and control which staff could access on the trust intranet. We observed staff to be bare below the elbow and wearing personal protective equipment, such as gloves and aprons, when delivering care.
- There were enough sinks and hand gels available for hand washing. Weekly audits of hand washing practice were reviewed in CMTC, with scores ranging between 88% to 97% during the four weeks prior to inspection.
- However, we saw a standard operating procedure for hand washing which was dated April 2005, with review dates in 2008, 2010, 2011, 2013 and 2015.
- We observed some staff did not use hand gel in between patients in radiology departments. We also noted that staff did not wipe down a knee holder following a patient's use during Magnetic Resonance imaging (MRI).
- Some rooms were being used both as consulting rooms and treatment rooms; we saw there were no routine infection control procedures followed for cleaning rooms and wiping down treatment couches in between patients in these cases
- In the hospital outpatient department we saw the door to the dirty utility room was ajar, with a cabinet open containing pregnancy tests, urine test strips and wipes.
- We requested but saw no records to confirm that cleaning records were maintained for treatment rooms in the hospital outpatient clinic [A] we also noted that there had been no recording of legionella monitoring in clinic [C]. However we did see records to confirm that these checks had been maintained in radiography and cardio-physiological testing areas. The trust has confirmed that legionella testing is completed and held in the housekeepers file.
- An assisted toilet in an antenatal clinic had not been checked on the day of our inspection and we observed the sanitary bin was full and overflowing. This was raised to the outpatient manager at the time, who responded immediately to the situation. However, we did observe cleaning records had been completed for the assistance toilet twice daily on previous days.
- In the Cheshire and Merseyside Treatment Centre the portable X-ray machine was covered in a thick layer of dust. However, we saw X-ray cassettes were cleaned by radiographers after each patient use. We spoke with staff and were advised that no cleaning records were kept in radiography rooms.
- Cleaning audit score sheets were displayed in the hospital outpatient department as Infection prevention and control advice notices for visitors. Scores were 91% in January 2017 and 99% for March 2017. No results were displayed for February 2017.
- Weekly hand hygiene audits were completed in outpatient areas. We observed records in the Cheshire and Merseyside Treatment Centre which indicated scores ranged between 88% to 97% over three months prior to inspection.

Environment and equipment

- A security tagged resuscitation trolley was available in a corridor at the back of outpatient clinics A& B. This was

easily accessible for these main clinic areas and all resuscitation equipment was checked daily, as well as a whole trolley check weekly. We saw signed and dated records which confirmed this.

- A resuscitation trolley was available adjacent to clinic C. We found checks for this equipment were signed as complete, however, however we noted that these were not in chronological order. We saw that all equipment was correct and as recorded.
- An oxygen cylinder half full was secured to the wall in the Cheshire and Merseyside Treatment Centre (CMTC) outpatient department. We saw the date due for calibration of the cylinder was October 2015. We escalated this to the manager who advised that the calibration team had been on the unit two months ago; the manager was going to follow this up with the team.
- We saw CMTC resuscitation equipment and records had been audited by the resuscitation officer in January 2017. All daily and weekly resuscitation equipment checks had been recorded, dated and signed for the previous six weeks.
- In the CMTC a resuscitation trolley was located outside the magnetic resonance department on the X-ray corridor. This was last signed as having been checked on 1 March 2017, however paediatric stock had been checked every day for the previous 3 weeks. When we checked stock on the resuscitation trolley we found this was in date. The lack of clear recording may impact on the trusts ability to monitor the equipment available for emergency treatment of patients.
- In the CMTC the Computed Radiography (CR) reader was located on a main corridor outside the X-Ray room. This created a radiation risk for other staff potentially entering the X-Ray room during exposure. We observed a student leaving the X-Ray room through an unlocked door to take cassettes for processing. The radiographer watched the door to ensure the student did not walk in during exposure, however this created a risk. Doors should be kept locked during exposure to prevent this under Ionising Radiations Regulations 1999 (IRR99)
- There was a CR reader outside two X-ray rooms where patients exited. This meant patients could see their own or other patients X-rays and clinical details visible on screen. This was an unsupervised area where patients could have access to images performed in other X-ray rooms. We were concerned this was a potential breach of patient confidentiality and this was raised to the trust during inspection.
- As part of the IR99, regulation 32 Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER), a suitable quality assurance programme must be in place to ensure safe exposure to ionising radiation. Records we reviewed confirmed several breaches of this regulation.
- Quality Assurance (QA) checks for the theatre image intensifier in the Cheshire and Image intensifiers in CMTC rooms one and two had dates missing for checks in March 2016, July 2016, October and November 2016.Merseyside Treatment Centre (CMTC) had not been completed between February to November 2016.
- Checks on the one of the portable X-ray machines had not been completed for over 12 months; evidence also showed this had only been completed once, in February 2016.
- Weekly checks of warning lights on the X-ray machine in the urgent care centre at Halton hospital had not been recorded between 2 to 12 December 2016 and 17 to 31 January 2017.
- The hospital used directorate policies based on the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). We found the policies and procedures relating to IRMER were appropriate and up to date. Documentation was available to staff via the hospital intranet and up to date paper copies were also seen. We reviewed 'local rules' in five locations which were all within review dates.
- We saw radiation controlled areas were clearly designated; full personal protective equipment, including lead gowns, were available and a pause and check checklist was displayed, following best practice.
- Biennial independent radiation protection surveys had been performed and reports contained recommendations that had been actioned.
- Staff wore radiation monitoring badges and records of staff results were stored on the computer to assess exposure over time and regularly reviewed by the local radiation protection supervisor (RPS).

Outpatients and diagnostic imaging

- We saw records of training for staff who were Radiation Protection Supervisors (RPS). There was an RPS available in each clinical area where patients and staff were exposed to radiation.
- Maintenance contracts were in place for radiology equipment. Staff told us that equipment was repaired quickly and this caused minimum disruption to service.
- In the main outpatient department, large ophthalmology machines were stored in the corridor at the back of clinic area C. This was raised with the manager who advised currently a new permanent clinic room was being located for ophthalmology.
- In radiology services staff reported equipment problems as an issue, with old equipment failing to be replaced. An ultrasound machine had been taken out of action eight months previously as it was deemed unsafe. At the time of our inspection, this equipment had not yet been replaced. Staff told us they have been told this issue was "not high on the agenda" and it was a "battle to get funding". Managers confirmed there was a business case in place and a rolling programme for replacing equipment when it expired was being developed.
- Patients attended the phlebotomy clinic for blood tests. The clinic had two specialist phlebotomy chairs, however one of these had cracked arm rests. Staff advised new arm rests had been ordered in January 2017 but had no indication when these would be replaced. We also saw the other chair had a torn seat; records we reviewed confirmed that this had been documented on the cleaning sheet in January 2017.
- Portable electrical appliances we checked in the outpatient department were labelled, with service dates clearly marked and in date. However, we saw many labels were missing on portable equipment in Magnetic Resonance scanner areas.
- We saw audiology equipment was checked by medical engineers and details recorded appropriately for timpanometer and aurical programming hearing aids machine.

Medicines

- During our inspection we reviewed procedures for safe storage and management of medicines. We saw medicines were stored in secure cupboards with access restricted to authorised staff.
- A drugs cupboard was checked in the ENT and Gynaecological clinic where we saw all medicines were recorded and stored correctly, however the room was overfilled with equipment. We saw trolleys were stored in here, making access to the drugs cupboard difficult. The trust has confirmed that following the inspection this area has been de-cluttered, and an additional medicines cabinet purchased.
- Medicines requiring storage between two and eight degrees centigrade were kept in locked fridges. Fridge temperatures were checked and recorded daily.
- There were patient information leaflets relating to specific medicines and treatments available in outpatient areas. The leaflets included what the medicine does, how to take and possible side effects.
- Staff in some outpatient areas used patient group directions (PGD's) to administer medicine without a doctor, such as eye drops or contrast media. The procedures and staff competencies were inspected and complied with standards.

Records

- At the time of the inspection the medical records department recorded 99.7% availability of records. We inspected the audit records for a period of 3 months and found 11 cases of missing records. Nine were located in time for the appointment and two were duplicated. Records we reviewed confirmed that an escalation process was in place and missing notes were reported to divisional management for investigation. Minutes confirmed that themes identified following investigations, were discussed at outpatient steering group meetings.
- 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 identified the problem and had addressed any potential concerns. There had been 200 patients that did not attend their appointment that had been subsequently contacted and offered appointments. At the time of the inspection there were 33 patients that still needed a follow up appointment. Consultant review of these cases had identified there had been no adverse impact for these patients.

Outpatients and diagnostic imaging

- After the introduction of the electronic record system in November 2015, appointment outcomes were recorded electronically by Consultant and Specialist Nursing staff on a bespoke system. This removed the risk of paper outcome forms being 'lost' in the system, which may have affected patient safety and referral to treatment recording. The process was audited daily to ensure any appointment without an outcome was followed up with the clinician. A daily check of outcomes against the bespoke system and the electronic record system was also performed to ensure all patients were accounted for.
- We reviewed eight sets of case notes in Halton hospital outpatients. Case notes were kept in secure trolleys behind the main reception desk, out of public view. 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, with no letters attached or included. Admission front sheets were observed in one 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 and communication forms. These were dated and signed where appropriate, or recorded as dictated but not signed, for urgent communication purposes.
- We saw a multi-disciplinary single patient record sheet was used in one patient's notes. This recorded patient allergies, height and weight, prescription details for eye drops. However we could find no signature or documentation regarding administration of these eye drops. Also, this file had an empty record sheet for cataract treatment. It was unclear whether this was in preparation for a future appointment as eye test results; a pre-operative assessment sheet was dated 10 July 2015. A consultant letter to GP dated 16July 2015 confirmed the patient was on a waiting list for cataract surgery.
- There was evidence of patient allergies recorded and clinic attendances in chronological order. Some patients with chronic conditions had several volumes of notes, which were numbered according to the IT system.
- Thirteen patient records were reviewed in X-ray. These all showed details of clinical history, with justification under IRMER and dose information completed. A random sample of ten x-rays from the previous three days were checked and image quality was adequate.

Safeguarding

- The trust had a policy for safeguarding adults and children, which informed staff who the named professionals were that could be contacted for advice. We found staff were aware of the policy and gave us examples of appropriate practice.
- The trust provided training in safeguarding adults and children. Outpatient and diagnostic staff were trained up to level two for both adults and children. Overall the target of 85% in all levels with all staff groups was met.
- We saw prompts and checklists for staff to ensure correct identification was made prior to patients receiving any diagnostic imaging. We observed patients receiving a full identification check and correct dose information being recorded in notes.
- Staff we spoke with, were aware of safeguarding procedures and could describe relevant examples of a safeguarding issue. For example a physiotherapist had highlighted an issue of a baby not having attended an appointment at a hip clinic. The patient's address details were checked and through contact with the GP it became apparent this baby had also failed to attend appointments at other specialist hospitals. This prompted contact with the trust and local authority safeguarding teams for follow up.
- Four members of nursing staff in outpatients had completed level three safeguarding training. One outpatient manager had previously been seconded for a year to work with the trust safeguarding team and was able to provide support for safeguarding issues to staff in the department.
- General paediatric clinics were held twice a week in the outpatient department, however nursing staff attending these were trained to level two safeguarding only. This did not meet guidelines recommended in the 2014 intercollegiate document: "Safeguarding children and young people: roles and competencies for healthcare staff". No children were seen for appointments at the Cheshire and Merseyside Treatment Centre.

Outpatients and diagnostic imaging

- Children's attendance at outpatient appointments was monitored and a did not attend (DNA) flowchart was in place. If a child did not attend (DNA), an appointment, the consultant was informed and would send a letter to parents or carers. Following two DNA appointments, a referral would be made to the safeguarding team for follow up. The department manager recorded details of safeguarding referrals, we saw three referrals had been made during 2016 for children who had failed to attend appointments.
- The audiology clinic saw children for hearing tests. The audiologist had completed level 3 safeguarding training and the assistant audiologist completed level 2. No safeguarding referrals had been made in audiology, however staff could describe this process and knew what actions to follow if they had a safeguarding concern.

Mandatory training

- Mandatory training was delivered in a mixture of e-learning and face- to-face training.
- The trust set a target of 85% for completion of mandatory training. Subjects included in mandatory training were fire safety; infection control; moving and handling; health and safety; equality and diversity. The trust met its 85% target for completion of mandatory training modules for medical and nursing staff, with the exception of Medicines Management. For this module, compliance ranged from 100% to 13% across staff groups, with a total compliance of 61%. Health and safety level 3 also had only 77% compliance.
- A healthcare assistant who had recently started working in outpatients, confirmed they had attended a full time induction which was lasted one week. Subjects covered in induction included manual handling, fire safety, risk assessment, infection prevention and control; basic life support. Department staff provided a local induction including fire safety procedures and access to different supplies.

Assessing and responding to patient risk

- There were controlled area illuminated warning signs at the entrance to each diagnostic imaging area that conformed to radiation regulations and yellow radiation danger warning signs. Signs were evident in the waiting rooms informing patients to let staff know if they may be pregnant. Radiation Protection Supervisors were available in each clinical area.
- An emergency call system was in place in Radiology departments, with an escalation procedure to be followed if patients became unwell during investigations. Staff in MR departments described how a patient would be removed quickly and safely from the MR controlled area to a safer area for further treatment, if they became acutely unwell during procedures.
- Oxygen cylinders and suction machines were available at CT and MR scanner reception areas for patient use in an emergency.
- We observed patients having X -rays and saw a radiographer had noticed there could be artefacts on the patient, so the patient was sent back to the changing room to remove these.
- Outpatient staff across departments, were able to describe how to proceed if they were aware of a patient becoming unwell. For example, staff in phlebotomy clinic described an incident where a patient had suffered an epileptic fit during blood tests. An alarm call was raised, which nearby nursing staff responded to, attending to the patient emergency.
- There was no out of hours diagnostic intervention service provided and staff had recognised this as a risk. Actions had been taken to improve this service, with a new standard operating procedure developed, for patients to be transferred to local NHS hospitals for these urgent services.
- Staff in cardiorespiratory services conducted physiological exercise tests with patients using treadmills and other equipment. Staff described how they monitored patient's condition during these tests and would bleep the registered medical officer in case of any concern.

Nursing staffing

- The last staffing review within the department used a competency based workforce planning tool. At the time of inspection, total nurse staffing for outpatients was 35.9 whole time equivalent staff across Halton and Warrington sites. Of these whole time equivalents, 24 were healthcare assistants (HCAs).

Outpatients and diagnostic imaging

- 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 ahead according to clinic demands and staff worked flexibly to cover this.
- Sickness absence in outpatient Band 5 nursing staff was currently almost at 50%, with three out of seven staff absent due to sickness and maternity leave.
- There had been a trial of band 4 Assistant Practitioner roles in the trauma and orthopaedic centre. The manager advised these had not worked as well as anticipated, as these staff were not able to hold drugs keys within the scope of their roles.
- In December 2016 the radiology department had vacancies for both radiologists and radiographers, particularly in ultra-sonographers. This reflected current national shortages for these clinicians. The trust also reported vacancies in histopathology and outpatient appointments staff.
- The trust provided data regarding use of bank and agency staff, however this could not be analysed for rate of use across outpatient departments. Bank staff were not used in outpatients.

Medical staffing

- Trust data indicated a 5.3% vacancy rate in medical staffing for diagnostics and 2.7% for radiology medical staffing. This represented 2 whole time in diagnostics and 0.5 WTE in radiology.
- The turnover rate for medical staff in diagnostics was 7.8% and for radiology 10%. This reflected a national shortage in Allied Health Professional staffing.
- There was no specific medical consultant cover in outpatients. Outpatient clinic sessions were incorporated into job plans for consultants working in different specialities.

Major incident awareness and training

- The trust had a major incident and business continuity plan. Staff were trained as part of their induction training and details of emergency planning procedures were available on the trust intranet. Senior nursing staff had good knowledge of emergency planning procedures.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate the effective domain. We found :

- The radiology governance lead was responsible for ensuring all pathways and policies were regularly reviewed and updated in line with NICE and Royal College of Radiographers guidance. The documents we inspected conformed with current guidance.
- Whilst we saw there had been significant improvement in completion of appraisals for nursing staff since our previous inspection , with these rates moving from 40% to 82% at January 2017, the appraisal rates for nursing staff were below the trust target of 85%.
- We saw evidence of posters of research work undertaken displayed in radiology. The work had assessed techniques against NICE guidelines.
- Protocols for different imaging techniques were available for staff to follow in radiography. These were consistent with those used at Warrington. Halton hospital also used the same Patient Archiving and Communications System (PACS) as Warrington hospital to ensure collaborative working.
- The diagnostic reference levels were monitored and assessed during the annual radiation protection advisor inspection. Any discrepancies were highlighted, discussed and actioned.

Evidence-based care and treatment

- Patients were assessed and treatment was planned and delivered according to evidence- based practice such as NICE guidelines, standards and best practice.
- Protocols for different imaging techniques were available for staff to follow in radiography. These were consistent with those used at Warrington. Halton hospital also used the same Patient Archiving and Communications System (PACS) as Warrington hospital, to ensure collaborative working.

Outpatients and diagnostic imaging

- A policy was in place that had been developed locally to assess patients for risk of contrast induced acute kidney injury (AKI). The policy was developed based on NICE guidance.
- Medical photography staff had worked with the clinical governance department to develop a medical illustration policy. This was being assessed for level one accreditation with the Institute of Medical Illustrators. These staff were also involved in development of a trust mobile phone policy.
- The ophthalmology department participated in a several patient experience audits and used results to improve patient outcomes. This included an amblyopia review, stroke service review and school vision screening. Standards and outcomes were measured against national standards.
- The rheumatology department had implemented a new approach of shared care between primary care (hospital services) and secondary care (community services). A medication database had been set up, providing information for consultants and GPs about patients' prescriptions and any blood monitoring. A retrospective audit of 40 patients was being undertaken, with formalised findings due to be reported to trust board and participating GPs.
- We saw evidence of posters of research work undertaken displayed in radiology. The work had assessed techniques against NICE guidelines including 'Paediatric elbows', 'Lumber spine GP referrals' and 'Pelvic radiography'. The audits ensured continued quality and best practice.

Pain relief

- The fracture clinic had a supply of the medical gas Entonox to provide patients with pain relief, if required, during examination and treatment. The gas was stored appropriately in a locked store room.
- Staff informed us that pain medication was not generally available for patients in the clinic. We were told that patients would be advised to take oral pain relieving medication at home prior to an appointment if it was deemed necessary, for example during a dressing change.
- Patients we spoke with, confirmed that pain management was discussed with them, particularly after any invasive procedures they may have undergone.

Patient outcomes

- Between December 2015 and November 2016, the follow-up to new rate for Halton hospital was higher than the England average.
- Between December 2015 and November 2016, the follow-up to new rate for Widnes Health Care Resource Centre fluctuated above or below the England average.
- We saw evidence of participation in various audits in outpatient and diagnostic services. For example, Audiology staff were completing a tinnitus Functional Index – patient perception – qualitative audit. Staff were proud of this service, which included retraining therapies and support for patients and their families.
- Records confirmed that the physiotherapy department routinely measured appropriate patients emotional and physical condition with a 'Back to Action' questionnaire. The back rehabilitation programme was audited every three years and measured against NICE guidance.
- The specific learning difficulties department undertook annual monitoring of patient outcomes in order to assess their achievement of goals, including the impact of orthotic intervention on progress and measure patient and school satisfaction. Results were positive and actions and recommendations made.
- Warrington and Halton hospitals trust does not currently have any services registered with the Improving Quality in Physiological Services (IQIPS) accreditation scheme.

Competent staff

- Data provided by the trust prior to inspection showed 40% of nursing staff in outpatients had completed their appraisal. This was lower than the trust target of 85%. A new nurse manager was in post and work had started to address this.
- Records confirmed that in radiology, the number of staff that had undertaken an appraisal was 93% and 91.8% of Radiology staff had completed their personal development review.

- Managers supported nursing staff towards their revalidation, with records of reflective discussions held during one to one supervision meetings. These discussions included review of incident learning, any competencies or learning and development progressed for individual members of staff.
- Staff had opportunity to access training and development in relation to their role. A member of staff had acted as an interim manager for a short period and had found the supervision and leadership review helpful whilst acting in this post. They were being supported by managers to apply this process to their current job role.
- Orthopaedic consultants had opportunity to take study leave to visit other centres. We heard from one consultant who had visited national centres to follow a patient journey and observe other techniques.
- Staff participated in continued professional development in the department with regular learning sessions. A presentation was given to diagnostic staff to provide staff with awareness of complaints, risks and safe practice techniques.

Multidisciplinary working

- A multidisciplinary team co-ordinator worked within the breast screening service across sites and teams. The screening service provided at Warrington covered patients from four geographical boroughs and Skype meetings were co-ordinated on a weekly basis. Meetings included consultants from other trusts along with breast care nurses, pathologists and radiographers.
- Service level agreements were in place with other local hospitals to provide services to Warrington patients when the trust were unable to provide a local service. Interventional radiology had an agreement for a hospital in Chester to provide care out of normal working hours when emergency treatment was required.
- We saw evidence of collaboration between staff in other hospital trusts in many areas of outpatients and diagnostics specialities. These included ultrasound, breast screening, physiotherapy and urology.
- Physiotherapy, occupational therapy and orthotic services were available to support patients for rehabilitation.
- A clinical photography service was provided covering Warrington and Halton sites. The service worked closely with tissue viability nurses to manage effective pressure care. This service was also provided under service level agreement to other NHS hospitals in the region. Clinical photographers worked closely with staff trust safeguarding leads in cases of non-accidental injury to children.

Seven-day services

- Most of the outpatient clinics were open Monday to Friday 8am till 5pm. Waiting time initiatives meant that some services provided late night or Saturday morning services.
- Diagnostic services were available seven days a week. Outpatient appointments were available for non-urgent plain film imaging six days per week. MRI appointments were available 12 hours per day at the weekend. CT scanning was performed 24 hours a day for inpatients and at weekend for consultant lists. Ultrasound provided a regular Saturday morning and afternoon service. There were community based radiology services that supported ambulatory care pathways.

Access to information

- All staff had access to the most current policies and procedures via the trust intranet, which could be accessed at any computer terminal.
- We saw evidence in health care records of information being shared between specialities caring for an individual. Referrals to other professionals had taken place and responses received.
- All diagnostic images were reported in time for the patient's next appointment, which meant there were no delays in treatment decisions. This was achieved by trust radiologists, reporting radiographers and a local agreement with nearby trusts in the area.
- The trust used the electronic records and appointments system. Paper records were still made available in clinic but all clinical staff could securely access patients' details from any terminal.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust reported that between January 2014 and December 2016Mental Capacity Act (MCA) training had

been completed by 75% of staff within Outpatients. Following the inspection the trust provided that following assurance; The poor training compliance has been noted following the CQC inspection. The adult safeguarding team had, in the weeks leading up to the inspection, in line with the external safeguarding review, examined all aspects of adult safeguarding training and reviewed the level at which this should be delivered. Improvements were being made with regard to MCA training and the program had just begun to be rolled out at the time of the inspection, this new face to face training is delivered at level 3 to all appropriate medical, medical care and nursing staff supporting the eLearning package already in place.

- All staff we spoke with had a good understanding of when consent would be sought, and were able to explain guidance from the Mental Capacity Act.
- Patients we spoke with, attending orthopaedic appointments prior to having surgery said their consultant had explained the benefits and risks of treatment in obtaining their written consent. We saw records confirming consent procedures were completed accurately.
- We observed X-ray procedures where the radiographer explained treatment prior to seeking verbal consent for this. Consent was clearly recorded in case records following this.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- We observed many patients receiving considerate, respectful care. Staff gave clear information and kept patients informed throughout their appointment.
- Patient satisfaction surveys had received feedback from a large number of patients in several clinical areas. The results were positive, with an average score of 4 out of 5 and nearly all patients stating they would recommend the service.
- We saw that patients' privacy and dignity was respected whilst they were receiving care; staff communicated in ways which supported and reassured patients when attending appointments.
- Patients told us they felt supported and involved in making decisions about their care and treatment

However:

- Some patients said they had not always received details to know what to expect at appointments or to clarify follow up information.
- We observed some staff whose identity badges were not clearly displayed and they did not introduce themselves to patients.

Compassionate care

- Reception, nursing and medical staff were pleasant and caring in their approach to patients. One patient told us the consultant showed understanding and "had a really nice attitude" when explaining the reason for a delayed appointment. They said nursing staff and students introduced themselves, shaking hands with patients.
- In rheumatology clinic, patients said staff "were marvellous and couldn't have treated you better". Staff offered tea, toast and biscuits to patients who were waiting here. Another patient said the nurse specialist is "fabulous and nothing's too much trouble".
- We heard from one patient about a poor experience of care recently at Warrington hospital where they had lengthy waits in different departments during the day until being admitted to the ward at 11.30pm. The patient described how they were "in agony all day" and had not been informed of the level of pain they may experience following a clinical procedure. The patient had taken their own discharge and returned to the day ward at Halton subsequently, where they described their care was "absolutely superb", without any experience of discomfort following this.
- Patients said staff were considerate and respected their privacy and dignity. Patients were directed to clinic areas from the main reception desk at Halton hospital entrance. This was a busy public area, however notices

were displayed asking patients to wait until the receptionist was free for booking in. This ensured some level of privacy for patients whilst discussing their details.

- An information desk run by volunteers was adjacent to the hospital main reception and we also saw many patients and visitors receiving directions from volunteers here.
- The Cheshire and Merseyside Treatment Centre reception was less congested, offering patients greater privacy when booking in for appointments.
- Nursing and medical staff working in clinical areas ensured that consultation room doors or cubicle curtains were closed during patient appointments. Signs indicated when a room was in use, to maintain patient privacy. We saw nursing staff knocking on doors to check rooms were empty before entering.
- Patients having x-ray investigations were provided with gowns to preserve their dignity.
- We observed patients undergoing blood tests taken and saw staff were encouraging and reassuring to patients during these. A curtain was closed in between the two patient seating areas to provide privacy during these tests.
- Notices were displayed offering a chaperoning for patients if they required this. Nursing staff told us they realised patients didn't always ask for chaperones, so they asked patients directly at the start of their appointments if they would like a chaperone. A consultant working in the pain clinic said they frequently used patient chaperones and staff were always available for this. We did not speak to any patients who had requested this however.
- We saw staff in phlebotomy clinic wearing trust ID badges but these were tucked in their pocket so their names weren't visible. We did not hear staff introduce themselves by name or role to the three patients we saw attending for blood tests.

Understanding and involvement of patients and those close to them

- Radiography staff took time to speak with and explain procedures to patients, communicating clearly throughout. Patients told us they were very impressed with the service and "staff were brilliant".
- Three patients out of ten whom we asked said they had not received any written information about their treatment. One patient having treatment for a pancreatic condition said they had been advised a low fat diet, but were not given any specific further details. They told us they were hoping for more information at today's appointment. Another patient told us that they had received three letters in the last six months cancelling their appointments. The patient had appointments for three different things booked and the cancellation letter did not clarify which clinic was cancelled. The patient's daughter said "we had to play a guessing game" which caused the patient concern and inconvenience.
- One patient attending for their first appointment was unsure what the appointment was related to or what to expect. They said they had received no information or leaflets regarding the appointment.
- Young people attending appointments at orthodontic clinics said the dentist spoke directly with them but also involved parents.

Emotional support

- We saw staff speaking with patients in a sensitive and understanding manner, providing reassurance when patients were anxious about their appointment. Patients who required emotional support said they felt this was good.
- Patients told us consultants had provided information about their condition and they felt fully supported in considering their decision about having surgery. During inspection, several patients were due to meet jointly with a consultant prior to their knee surgery, for the consultant to share general information and advice about the operation.
- Leaflets were available for patients in outpatient areas, providing information about their condition. These included contact information for patient support groups, including a display of information about the British Lung Foundation and a local voluntary group to help with their respiratory problems.

Outpatients and diagnostic imaging

- Patients preparing to undergo surgery for total hip or knee replacements were provided with leaflets and information about the operation and what to expect post operatively.
- Posters were displayed in X-ray reception areas providing information about the risks of radiation, also indicating the risks balanced with the benefits of X-ray investigations. We saw this provided good information about radiation safety for patients.
- Consultants in pain clinics had identified a need for psychological support services in response to service demands, however we were told, resources were not available for this currently.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Patients received timely access to initial assessment, diagnostic and urgent treatment at Halton and Warrington hospitals. The referral to appointment times were better than the national average in most specialties. Rapid access clinics were available where required and we saw evidence of this during the inspection.
- Referral to treatment times were monitored continually and these were consistently better than the England average, except for urology, ophthalmology and paediatric orthopaedics. Measures were being implemented to improve access in these areas.
- Waiting times for referral and treatment for cancer were better than the England average, against all three cancer targets.
- The Cheshire and Merseyside Treatment Centre was a light and spacious environment with comfortable facilities for patients waiting for appointments.
- Diagnostic waiting times were excellent where less than 1% of patients waited more than 6 weeks for an appointment. Comparisons with other trusts demonstrated that Warrington and Halton had shorter than average waiting times for CT, MRI and ultrasound.
- There were systems in place to meet the needs of individuals such as those living with dementia, a learning or physical disability.
- Case records were available for patient for over 98% of appointments.
- Where possible, additional late clinics were scheduled in response to and waiting list demands.
- Electronic patient records could flag patients with additional needs such as dementia, however pathways for managing any identified needs were not in place clearly. Staff said these patients were managed on an a case by case basis.
- Interpreter services were available for patients who required these.

However:

- Halton hospital clinic facilities were generally congested and there was insufficient seating for patients in some clinic areas. Managers said clinics were running at full capacity on a daily basis.
- Did not attend rates were higher than the England average.
- Many patients said parking was a difficulty and signage to departments was unclear.

Service planning and delivery to meet the needs of local people

- Most clinics were held Monday to Friday 8am to 5 pm, with some additional late and Saturday morning clinics as waiting list initiatives.
- Between October 2015 and September 2016 the ”did not attend” rate for each site was higher than the England average. Clerical teams would monitor attendance levels, contacting referrers to advise and rearrange appointments where indicated.
- Clinic facilities at Halton hospital appeared generally busy. During inspection, we saw there was adequate seating in clinic A, the main outpatient waiting at Halton hospital. However, other clinic areas were much more congested and cramped. Clinic C had 23 seats in the waiting room, which was insufficient for the numbers of patients attending. Décor and furnishings appeared generally rather run down in clinic areas on the hospital site.

Outpatients and diagnostic imaging

- Treatment cubicles were adjacent to a corridor at the back of clinic C, with screens used around the cubicles. We were concerned about patients' privacy and dignity in these cubicles. The manager advised this had been escalated to the estates department and senior managers.
- Refreshments were not available in the outpatient clinic areas we inspected, although there was a café serving light snacks and drinks at the nearby main entrance. Some patients commented there was no cashpoint machine available and the restaurant only accepted cash payments.
- General Paediatric outpatient clinics were held twice a week in the main outpatient department and a small area of the waiting room was furnished with a children's table and chair. Toys were provided in clinic consultation rooms, however the main waiting area was lacking in child-friendly provision otherwise.
- The ophthalmology department provided a regular Saturday morning clinic in order to meet demand.
- The environment in the Cheshire and MerseysideTreatment Centre was light and airy, with spacious seating in waiting areas and clear signposting to clinic areas. A vending machine was available providing refreshments for patients. Wheelchairs were available at hospital entrances for patients who required these.
- The majority of patients we spoke with told us parking was a difficulty and it was hard to get a space. Signs were a little confusing for car parks, one patient ended up parking the other side of the hospital for an appointment. Some said parking could be expensive if you had to attend appointments on a frequent basis. A patient with a blue badge permit for disabled parking commented they had attended the hospital for 20 years and were dissatisfied with having to pay car parking charges.
- A free shuttle bus service operated between Warrington and Halton hospitals to assist patients attending appointments at both sites.
- We found directions to different clinic areas were not well signposted with many comments from patients confirming this. However, we only heard of one instance of a cancelled appointment from patients we spoke with. Patients said it would be helpful to receive a hospital map with their letter appointment.
- One patient had an appointment at the Delamere centre and had checked where to find this on the the trust website prior to attending. They told us they website information was unclear about this and other centres. They had also been concerned to receive their appointment for the Delamere centre as this is a cancer treatment centre; however this was not the reason for the patient's appointment.
- A comments book was provided for patients at reception. We saw most of the negative comments were about parking availability.
- The CT scanner at Halton was currently being installed, with building work proceeding to accommodate this. A mobile CT scanner was based at Warrington hospital to reduce any impact this may have for patient access and waiting times.

Access and flow

- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for non-admitted pathways has been better than the England overall performance. The latest figures for January 2017, showed 94.3% of this group of patients were treated within 18 weeks versus the England average of 89.3%. The trust has performed better than the England average for all of the last 12 months.
- Eleven specialties were above the England average for non-admitted RTT (percentage within 18 weeks). Four specialties were below the England average for non-admitted RTT. These were for Geriatric Medicine, Trauma and Orthopaedics, Urology and General Surgery.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for incomplete pathways has been better than the England overall performance and better than the operational standard of 92%. The latest figures for January 2017, showed 93.3% of this group of patients were treated within 18 weeks versus

the England average of 89.7%. Over the last 12 months the trust has met, and exceeded, the operational standard of 92% consistently, and has always been above the England average.

- Twelve specialties were above the England average for incomplete pathways RTT. Three specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks). These were for Geriatric Medicine, Urology and General Surgery.
- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. In the most recent quarter, Q3 2016/17, 93.5% of patients were seen by a specialist within 2 weeks of an urgent GP referral.
- The trust was performing in line with the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). In the most recent quarter, Q3 2016/17, 95.7% of patients waited less than 31 days from diagnosis to first definitive treatment.
- The trust was performing in line with the 85% national operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. In the most recent quarter, Q3 2016/17, 85.1% of patients waited less than 62 days from urgent GP referral to first definitive treatment.
- Between February 2016 and January 2017 the percentage of patients waiting more than six weeks to see a clinician was lower than the England average.
- The trust provided data for the number of clinics cancelled, between September – December 2016 .The average number of clinics cancelled with less than 6 weeks notice was 171 per month (9%) and with more than 6 weeks notice was 293 per month (15%).
- The main reasons for cancellations as reported by the trust were annual leave and study leave with a small number being due to Consultant sickness. In relation to over six week cancellations, a number of clinics were cancelled due to support service redesign and better capacity management. We inspected the audit sheets for 3 months prior to the inspection to assess the number of cancelled patients. There were none, which demonstrated the teams resourcefulness and dedication.
- Between April to December 2016 the trust reported 1.06% of patients were seen in Outpatients without their full medical record being available. The trust has reported that this was mitigated by creating temporary case notes created and merging these with a master case note once located.
- Referral documentation was now scanned on to the system so Consultants have the necessary information for new patients. Clinical (GP) letters are now stored electronically which allows consultant to view previous appointment details. Inpatient episodes are documented via clinical noting on the system which informed the ward of discharge appointments.
- Nurse managers told us the outpatient clinic was running at full capacity on a day to day basis. They expressed concern that new consultants had been appointed in colorectal and cardiac specialities which would result in additional demand for these clinics, however the clinics were already at a maximum level.
- Consultant requests for any additional clinics were directed to managers in order to assess whether staffing resources were available to cover these. No evening or weekend clinics were routinely scheduled in main clinics. However, when waiting list demands varied, additional late clinics were established to manage these. We were told that patients may not always receive notification of these appointments in time to attend. Outpatient staff did not have records of these patient numbers. The trust confirmed when additional capacity is created at short notice, appointments staff make every effort to contact patients by telephone, as well as sending a letter. The trust are monitoring the number of short notice clinic requests and only setting these when a clinical priority.
- Outpatient access teams report waiting times to clinical business units for managing capacity. At the time of our inspection, waiting list times were highest for urology at 18 weeks and paediatric orthopaedics at over 18 weeks. Improvement plans had been identified which were already having impact on reducing wait times for paediatric orthopaedic clinic.
- A high level of sickness absence in outpatient band 5 nursing staff was currently affecting the outpatient department's capacity to hold additional late clinics, to meet increased demand in patent flow.

Outpatients and diagnostic imaging

- Clinic appointments were scheduled to end at 5pm, we heard these frequently ran on until 7pm. Data was not available to confirm how frequently this occurred.
- We observed an audiology clinic held in a small clinic area, with insufficient seats available in the waiting area. This clinic was very busy during the inspection, with children and adults attending for appointments. Staff told us there could be up to 35 patients waiting at once, resulting in patients having to stand in queues on the main corridor on these occasions. Staff would advise patients to wait in other areas, but this would mean a delay in appointment lists, from staff having to go and look for these patients. This issue had been raised with senior managers, however we were not informed of any further actions here.
- Outpatient departments were resuming audits of patient waiting times from arrival to being seen by consultant, however no results were available at the time of inspection.
- Patients we spoke with during inspection waited between 10 and 40 minutes to be seen for their appointments, with three patients out of twelve waiting more than an hour. The main outpatient department displayed a whiteboard notice, to advise the length of any delays if clinics were running late.
- We heard from one patient who missed a physiotherapy appointment because they had misremembered the time of the appointment. They received a replacement appointment, to attend 48 hours later.
- Patients attending appointments in nurse led rheumatology clinics spoke positively about their access to these services. One patient attending regularly every three months said they could phone for an earlier appointment if they needed this in between scheduled visits.
- Audiology service ran a one stop clinic for ENT patients where doctors could send patients for hearing tests and receive diagnostic results on the same day as their clinic appointment. Hearing aids were programmed for individual patients' prescription needs. Patients were offered hearing aid fitting appointments at both Halton and Warrington sites, with follow up appointments six weeks after this.
- We saw an ophthalmology clinic had been cancelled during the inspection and these staff were redirected to clinics at Warrington hospital.
- Band 5 and band 6 radiography staff worked a planned rota between Warrington, Halton and Cheshire and Merseyside Treatment Centre to provide cover for X-ray between 8 am and 10 pm. An out of hours on call service was available for emergencies.
- The physiotherapy service were introducing a telephone triage system from April 2017 to improve patient access. Patients would be given with a contact number where an experienced physiotherapist would provide a ten minute appointment. During this, the patient would be assessed and directed with appropriate advice. This would include instructions for exercises, referral for treatment or referral to consultant, as required.

Meeting people's individual needs

- Although the electronic patient record could record and flag individual patient needs, such as for patients who had a learning disability, we noted that there was a variable response to additional needs that were identified. Staff in physiotherapy clinics said these were discussed on a case by case basis and any reasonable adjustments made accordingly.
- Managers in CMTC told us they had adopted principles of the "forget me not" scheme for patients who had dementia, with the establishment of a forget me not steering group. We saw one example of these changes, where toilet doors were colour coded to provide easier access for dementia patients.
- In audiology clinics, leaflets and pictorial aids were available to support patients who had a learning disability when they were having investigations and treatment.
- Patients attending appointments at the CMTC reported the disabled access was usually good, however on the day of inspection, one of the lifts was not working. This had been reported and was awaiting repair.
- Translation services were available to provide language support for patients where this was needed. In clinic B we saw a sign for "instant telephone interpreting", with

28 languages displayed, for patients to select from. Patients could identify their spoken language from this list and appropriate telephone translation services could be available.

Learning from complaints and concerns

- Between January 2016 and December 2016 there were 176 complaints about Outpatients. The trust took an average of 117 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be closed within six months . There were 72 complaints open at the time of data submission. These were open for an average of 192 days which was longer than the trust's timeframe.
- Staff described how they would always try and resolve any issues of concern or complaint by speaking directly with patients concerned. If patients remained unsatisfied, staff would direct them to Patient Advice and Liaison Services((PALS)for further support.
- Staff described a recent complaint regarding a patient who was unhappy about communication from a consultant in pain clinic. The issue was explored and the patient was offered to transfer appointment to a different consultant.
- Staff advised most complaints were related to waiting times in clinic; wherever possible, staff would keep patients informed about any delays.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Out patients and diagnostic imaging were managed in a stand-alone clinical business unit, with a degree of separate working from the Trust as a whole.
- There was a lack of communication between the staff and management. There had been significant change to the management structure and changes to the clinical business units but staff felt disconnected.
- Many staff said they did not know who their business manager was, stating the clinical business unit lead did not have time available to proactively manage the department. Some consultants said they had not been provided with any clarity regarding the management structure, which had been established 12 months previously.
- Whilst we saw there had been improvement in completion of annual personal development review for nursing staff, the rate was still below the trust target of 85% at the time of the inspection.

However:

- Staff generally reported positive experiences of working for the trust and were supported by their line managers. Many staff said the new outpatient matron had made a notable difference since they joined the trust seven weeks previously.
- The new outpatient manager had held a series of staff engagement events since joining the trust which 85 outpatient staff had attended.
- Staff spoke positively about the chief executive, describing how they had received direct response to emails when they had raised a recent issue of concern. This had been followed up with a staff meeting which the chief executive had attended.
- The trust had been awarded " Best training centre" out of 24 trusts for junior doctors' training.

Leadership of service

- The diagnostic business unit had recently employed an Allied Health Professionals (AHP) lead, who had not started employment during the inspection. The local management team were unsure what the role of this lead would be or how their management responsibilities would be affected.
- Many diagnostic staff told us they didn't know the clinical business manager, who had been in post almost 12 months, and felt there was poor connection to the clinical leads for each speciality. There were regular meetings between clinical leads and business managers but we were told that there were no regular diagnostic staff meetings. Information was emailed to each clinical area lead to be shared with staff. The principal radiographer told us there was an open door policy within diagnostic imaging for staff with concerns.
- Senior staff in radiology said their unit lead does not get any time to manage the service and that "management

was diluted at the top". They saw the Clinical Business Unit (CBU) lead had no time available to proactively manage the department. Clinical consultants were having to act up because of lack of management resources.

- Radiography staff at Halton said they need a Band seven radiographer to lead the area. Staff felt they were left on their own and would not know what to do if something serious was to happen, also there were no meetings held and there was a "closed door policy". They described having raised this with senior staff but there had been no further response. This had been reported to directorate leads.
- Staff were appreciative about the new outpatient matron, who was described as active in responding to departmental issues, since starting in their role seven weeks previously. Outpatient staff said they felt their voice was being represented at senior levels
- Many staff were positive that their leaders were visible and approachable. Staff told us 'Supportive line manager, recommend as a place to work.' We saw evidence of this in revalidation folders, where line managers had supported learning.
- Since the change in directives to CBU some consultants and their teams were unsure of who the leaders were. They had not been told the management structure, had not had introductions to their line manager and didn't know who to contact for annual leave.
- Staff spoke positively about the chief executive, describing how they had received direct response to emails when they had raised a recent issue of concern. This had been followed up with a staff meeting which the chief executive had attended.

Governance, risk management and quality measurement

- Risk registers were in place across the outpatient department, however the process for actively managing any risks identified was not clearly established. We saw risks being downgraded without clear reasons or judgement , without any clear identified mitigation or actions to address these.
- Four radiology risks were on the register with an assessed rating of 12. These had originally been rated at 16, but then had been downgraded in January & February 2017, with no rationale as to the change.
- We saw radiology incidents were not recorded on incident logs appropriately; there was an overall lack of evidence of learning from incidents in radiography.
- Following the appointment issues identified, patient access teams have implemented robust systems and pathways to manage patient referrals and follow up, with a daily validation report against this information. A data quality team was also in place to support this continuing area of development.
- We saw evidence in team meeting minutes that patient quality issues, including waiting times, were discussed, with actions reviewed where possible.

Vision and strategy for this service

- The trust had recently introduced a new organisational structure including the formation of eight new clinical business units across two divisions. The intention was to improve the support and engagement with staff at a clinical level and a new Allied Health professional (AHP) lead post had been created to be part of the leadership structure.
- We saw staff working in different services who worked hard and were committed to delivering the best patient care; however, staff we spoke with were not really aware of the trust's overall plans or future direction.
- The diagnostics clinical business unit sat within the acute care services division. The outpatients services however, had not been attached to any particular division as the clinical services were categorised by speciality.
- Some departmental managers were planning services with colleagues from the neighbouring trusts in preparation for the sustainability and transformation plans to be introduced. Plans were established and progress was being made towards its delivery.

Culture within the service

- Staff said generally they were supported by managers and felt involved in service developments. We heard consistent comments from staff about the culture of openness and working together at the hospital.

Outpatients and diagnostic imaging

- Staff had access to a "Speak out safely" link on the trust intranet to raise any concern anonymously. Staff described how this would generate a contact email response from the clinical governance department, however, we did not speak with any staff who had used this facility.
- We heard from a member of staff who said the trust had supported them with regard to a specific health need and managing role progression.
- One manager was proud that in their twelve years in post there had been no reported complaints against the attitude of staff.

Public engagement

- In the CMTC waiting area we saw a "what patients say" poster displayed. Some of the comments her included: efficient; nice to have everything done in one place; very friendly and approachable staff; professional and prompt service.
- We saw artwork in CMTC waiting area which had been completed by a patient. This was a colourful pictorial representation of a patient journey and experience.
- Staff at Halton had adopted the 'Hello my name is…' Kate Granger campaign badges and notices to improve communication with patients and visitors. We saw staff wearing badges and most staff introducing themselves to patients. However, we also observed staff in some areas who did not introduce themselves to patients and whose name badges were not worn correctly so as to be visible.
- Patient feedback was not routinely gathered in most clinics we inspected. The NHS Friends and family test was being reintroduced by the new nurse manager, but there was insufficient data at the time of inspection.

Staff engagement

- Staff received email bulletins from the trust and news was shared in intranet notices and staff forums. A staff member described these as "refreshing", from their different experience at other trusts. A weekly clinical bulletin was circulated by the Director of Nursing to all nursing staff.
- The outpatient manager had arranged a series of engagement sessions across the two trust sites and across all outpatient administrative and clinical staff, in order to familiarise herself with the team and to encourage staff collaboration. Four open sessions had been attended by 85 staff. A poster had been produced because of these sessions, which included staff beliefs and opinions about their role. The manager explained that her goal was a common vision "pledge for patients" to be established. Staff were motivated at these sessions and have ideas to fund raise and provide more health information.
- A staff recognition award scheme was in place, where staff could be nominated for 'going the extra mile" awards. The trust had an employee of the month and team of the month award.

Innovation, improvement and sustainability

- Junior doctors had voted Warrington and Halton hospitals as the "Best training centre" out of 24 local trusts.
- Radiographers participated in a north west research development programme and had presented a poster at the UK Research Council conference on shoulder X -ray orientation.
- Plans were in progress to establish virtual fracture clinics in CMTC for improving patient access and experience in management of simple fractures. Consultant and nursing staff had visited a centre in Glasgow where this had been implemented and were working to develop this over the next six months.

Outstanding practice and areas for improvement

Outstanding practice

Areas for improvement

Action the hospital MUST take to improve

Actions the hospital MUST take to improve

- The trust must take action to provide and maintain an assurance system that World Health Organization (WHO) checklists are completed appropriately as to the standard operating procedure.
- The trust should take action to improve the number of suitably qualified staff in advanced life support in recovery.
- The trust should take action to provide and maintain an assurance system that all anaesthetic machines are checked in line with trust policy.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- The trust should take action to provide and maintain an assurance system that all stocks are within their expiration date.
- The trust should take action to improve staffing levels across wards and theatres.
- Although mandatory training performance has improved since the last inspection. The trust should take action to improve their mandatory and clinical skills performance across all core areas.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (1) (2) (b) (c) (e) (f) **How the regulation was not being met:** Processes in place were not always followed to ensure safe care and treatment of patients under going surgery, to minimise the occurrence of never events. There were are insufficient staff in recovery areas that had received ALS training. Anaesthetic machines should be checked in accordance with corporate policy and records kept of daily checks. Equipment on trolleys was not checked to ensure it was all in date and there was no assurance system to ensure compliance. The CR reader was located outside the x-ray room in the Cheshire and Merseyside Treatment Centre presenting a risk of radiation exposure. Quality Assurance checks in accordance with IRR99 regulations for radiology equipment were not up to date. Records of daily checks of resuscitation equipment were not maintained consistently in radiology departments. Ultrasound machines in radiology had been deemed unsafe and these had not been replaced for eight months.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Health and Social Care Act (2008) Regulated Activities Regulations 2014, Regulation 15(1) (a)(c)(e)(2) **How the regulation was not being met:** Treatment couches were not wiped down in between patients in outpatient treatment rooms. Portable x-ray equipment was found to be covered in a thick layer of dust. Both phlebotomy chairs in outpatients were broken: one had cracked covering on the armrests and the other had a large tear in the seat covering. Clinic areas were congested and there was inadequate seating for some areas, with patients needing to stand in corridors whilst waiting.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act [2008] Regulated Activities Regulations 2014, Regulation 17(1)(2) (c) **How the regulation was not being met:** Records of x-ray investigations and patient information were stored in a Computed Radiography reader on a main corridor. This remained logged in with confidential records accessible to members of the public, in an unsupervised area.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...