Blackpool Teaching Hospitals NHS Foundation Trust

Blackpool Victoria Hospital

Inspection report

Whinney Heys Road
Blackpool
FY3 8NR
Tel: 01253655520
www.bfwh.nhs.uk

Date of inspection visit: 19 and 20 April 2022
Date of publication: 22/07/2022

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Blackpool Victoria Hospital

Inspected but not rated

Blackpool Teaching Hospitals NHS Foundation Trust is situated on the west coast of Lancashire and operates within a regional health economy catchment area that spans Lancashire and South Cumbria and supports a population of 1.6 million.

The trust provides a range of acute services to the 330,000 population of the Fylde Coast health economy and the estimated 11 million visitors to the seaside town of Blackpool. Since April 2012, the trust also provides a wide range of community health services to the 445,000 residents of Blackpool, Fylde, Wyre and North Lancashire. The Trust also hosts the National artificial eye service, which provides services across England.

The trust provides a full range of hospital services and community health services. These include adult and children's services such as health visiting, community nursing, sexual health services and family planning and palliative care. The trust provides tertiary cardiac, haematology and adult cystic fibrosis services to 1.5 million population catchment area covering Lancashire and South Cumbria.

At our last inspection in October 2021, we rated safe, effective and well led as requires improvement, caring as good and responsive for the trust overall as inadequate.

The trust had experienced significant challenges over the past 2 years due to the COVID-19 pandemic. There was significant redeployment of staff at the trust during that period to support staff in critical areas.

We carried out this unannounced inspection, from the 19 and 20 April 2022, of Blackpool Teaching Hospitals NHS Trust.

We undertook a comprehensive inspection of Medical Care Core Services, and focused inspection of Urgent and Emergency Care Core Services at Blackpool Victoria Hospital. We also undertook a focused inspection of Surgical Core Service to follow up on the section 29A warning notice issued on 25 October 2021.

We re-rated medical care core service and our rating of safe went down to inadequate and well led came up to requires improvement. We inspected but did not rate the urgent and emergency care and surgery core services.

Details for the summary for each core service inspected can be found later within the report.

A summary of CQC findings on urgent and emergency care services in Lancashire and South Cumbria.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Lancashire and South Cumbria below:

Lancashire and South Cumbria.

Our findings

Provision of urgent and emergency care in Lancashire and South Cumbria was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, integrated urgent care, acute, mental health, ambulance services and adult social care. Staff felt tired and continued to work under sustained pressure across health and social care.

We found demand on urgent care services had increased. Whilst feedback on these services was mostly positive, we found patients were accessing these services instead of seeing their GP. Local stakeholders were aware that people were opting to attend urgent care services and were engaging with local communities to explore the reasons for this.

The NHS 111 service which covered all of the North West area, including Lancashire and South Cumbria, were experiencing significant staffing challenges across the whole area. During the COVID-19 pandemic, the service had recruited people from the travel industry. As these staff members returned to their previous roles, turnover was high and recruitment was particularly challenging. Service leaders worked well with system partners to ensure the local Directory of Services was up to date and working effectively to signpost people to appropriate services. However, due to a combination of high demand and staffing issues people experienced significant delays in accessing the 111 service. Following initial assessment, and if further information or clinical advice was required, people would receive a call back by a clinician at the NHS 111 service or from the clinical assessment service, delivered by out-of-hours providers. The NHS 111 service would benefit from a wide range of clinicians to be available such as dental, GP and pharmacists to negate the need for onward referral to other service providers. People who called 999 for an ambulance experienced significant delays. Ambulance crews also experienced long handover delays at most Emergency Departments. Crews also found it challenging managing different handover arrangements. Some emergency departments in Lancashire and South Cumbria struggled to manage ambulance handover delays effectively which significantly impacted on the ambulance service's ability to manage the risk in the community. The ambulance service proactively managed escalation processes which focused on a system wide response when services were under additional pressure.

We saw significant delays for people accessing care and treatment in emergency departments. Delays in triage and initial treatment put people at risk of harm. We visited mental health services delivered from the Emergency Department and found these to be well run and meeting people's needs. However, patients experienced delays in the Emergency Department as accessing mental health inpatient services remained a significant challenge. This often resulted in people being cared for in out of area placements.

We found discharge wasn't always planned from the point of admission which exacerbated in the poor patient flow seen across services. Discharge was also impacted on by capacity in social care services and the ability to meet people's needs in the community. We also found some patients were admitted from the Emergency Department because they couldn't get discharged back into their own home at night. Increased communication is needed between leaders in both health and social care, particularly during times of escalation when Local Authorities were not always engaged in action plans.

How we carried out this inspection

During our inspection, we spoke with a variety of staff including consultants, junior and senior doctors, junior and senior nursing staff, healthcare support workers, pharmacists, divisional director of operations, deputy director of nursing, divisional director and head of department for the emergency department. We visited the emergency department and the same day emergency care unit. We reviewed patient records, national data and other information provided by the trust.

Our findings

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Medical care (including older people's care)

Requires Improvement 

Blackpool Teaching Hospitals NHS Foundation trust is situated on the west coast of Lancashire and operates within a regional health economy catchment area that spans Lancashire and South Cumbria.

Blackpool Victoria Hospital is the trust's largest hospital. The hospital employs approximately 6,900 staff and has 719 beds, including 643 general and acute beds. The medical care services at the hospital are provided by two separate divisions; the integrated medicine and patient flow (IMPF) division and the tertiary services division.

The IMPF division delivers the majority of medical care specialties at the hospital; including emergency medicine, general medicine, respiratory, care of the elderly, diabetes, frailty, diabetes, endocrinology, rheumatology, dermatology, acute stroke and rehabilitation.

The tertiary services division includes cardiology, cardiothoracic, cystic fibrosis, oncology, heart failure services and a national artificial eye service. They also provide services for the wider population of Lancashire and South Cumbria.

From December 2020 to November 2021, the medical care services at the hospital had 64,609 inpatient admissions; including 18,757 admissions to general medicine, 11,743 admissions for gastroenterology and 9,639 admissions for clinical haematology.

We previously inspected the medical care services during September and October 2021. The report was published in January 2022. We rated the service as requires improvement overall, with a good rating for caring, an inadequate rating for well-led and a rating of requires improvement for safe, effective and responsive. Following the inspection, we issued the trust-wide S29A warning notice which also applied to the medical care services and related to concerns about the management of incidents and the management of patients who were waiting to receive care and treatment.

Our rating of medical care services at this location stayed the same. We rated it as requires improvement because:

- We rated safe as inadequate and effective, responsive and well-led as requires improvement. We rated caring as good.
- The service did not effectively manage risks for patients with suspected or confirmed sepsis and for patients requiring rapid tranquilisation. Staff practice did not always reflect national guidance in relation to sepsis management and rapid tranquilisation processes. We received limited assurance around competency based training for staff in relation to non-invasive ventilation, sepsis management and the use of rapid tranquilisation.
- People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were worse than national standards across most medical specialties. There was a worsening trend in performance for patient waiting times and delayed discharges. Patients experienced frequent bed moves due to infection risks and bed capacity issues.
- The service did not have enough nursing and medical staff with the right qualifications, skills, training and experience. Shortfalls in consultant staffing in the gastroenterology and stroke specialties impacted on the delivery of effective care and treatment. Stroke specialist consultant and speech and language therapy support was not always available at weekends in the stroke unit.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Medical care (including older people's care)

- The number of staff who completed mandatory training and safeguarding training did not meet overall trust targets. The proportion of medical staff that had completed life support training and moving and handling training was significantly below trust targets.
- Whilst leaders understood the priorities and issues the service faced, key risks and issues affecting the service were not always managed effectively. Leaders did not always operate effective governance processes. Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues or identify effective and timely actions to reduce their impact.
- Risk assessments for patients admitted through the full capacity protocol were not always documented. Patients admitted as part of the full capacity protocol did not always have their privacy and dignity maintained or receive clear information whilst awaiting an inpatient bed.
- The number of staff that had completed their appraisals did not meet trust targets.
- Records were bulky, poorly organised and not always clear and up-to-date. Staff made reasonable adjustments to help patients access services. However, this was not always documented clearly in patient records.
- Staff did not always fully and accurately complete patients' fluid and nutrition charts. Integrated clinical dashboards were not used consistently across the services.
- Whilst most clinical audit outcomes were comparable to expected national standards, the service performed worse than expected in the sentinel stroke national audit programme.
- The services had not yet developed documented local strategies, which meant staff did not fully understand or know how to apply the strategic objectives and monitor progress.

However,

- Staff understood how to protect patients from abuse. The service controlled infection risk well. The service managed safety incidents well and learned lessons from them.
- Staff gave patients enough to eat and drink and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Medical care (including older people's care)

Mandatory Training

The service provided mandatory training in key skills. However, the number of staff who completed it did not meet overall trust targets. The proportion of medical staff that had completed life support training and moving and handling training was significantly below trust targets.

Mandatory training consisted of specific topics such as equality, diversity and human rights, fire safety, health and safety, infection prevention and control, moving and handling, conflict resolution, preventing radicalisation, adult basic life support (level 2) and safeguarding children and adults training.

Mandatory training was delivered through e-learning modules with some face to face training modules. The mandatory training was comprehensive and met the needs of patients and staff.

We identified concerns around mandatory training compliance during our previous inspection in October 2021. At the previous inspection, we reported that 72.4% of nursing staff and 65.7% of medical staff had completed mandatory training, which was below the trust target of 95% compliance.

During this inspection, we found that overall mandatory training compliance for staff across the medical wards in the integrated medicine and patient flow (IMPF) division was 87%.

Records for the IMPF division showed there had been some improvement since our last inspection in overall mandatory training compliance for nursing staff (91%), which was slightly below the 95% trust target. However, the proportion of medical staff that had completed mandatory training (63%) was significantly below the trust target and had not improved since our previous inspection in October 2021.

The overall medical staff training compliance for the IMPF division was below the trust target across most of the mandatory training modules. Overall medical staff training compliance was significantly below trust targets for training modules such as adult basic life support (level 2) training (44%) and moving and handling (level 2) training (21%).

Training compliance for nursing staff in the IMPF division was 82% for adult basic life support training and 73% for moving and handling (level 2) training.

We requested but did not receive any data relating to mandatory training compliance for staff groups specifically in the medical wards within the tertiary services division. However, the tertiary services division quality and governance dashboard (April 2022) showed overall compliance across the division was 85%, which was below the trust target of 95%.

Managers monitored mandatory training and alerted staff when they needed to update their training. The staff we spoke with told us mandatory training was accessible. We received a mixed response from staff in relation to access to mandatory training. Staff on some medical wards told us they were supported to complete their mandatory training whereas on other wards staff told us they did not always have sufficient time to complete their mandatory training due to busy workloads. Managers told us mandatory training compliance had been impacted by increased work pressures and staff sickness rates resulting from the on-going Covid-19 pandemic.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Whilst staff had training on how to recognise and report abuse, the number of staff that had completed it did not meet trust targets.

Nursing and medical staff received training specific for their role on how to recognise and report abuse.

The level of training was in line with intercollegiate guidance 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth' (January 2019) and 'Adult Safeguarding: Roles and Competencies for Health Care Staff' (August 2018) states that clinical staff in the medical wards should receive at least safeguarding level 3 adults training and at least level 2 for children's safeguarding training.

Records for April 2022 showed 94% of nursing staff in the integrated medicine and patient flow (IMPF) division had completed adults safeguarding (level 3) training and 92% of nursing staff had completed children's safeguarding (level 2) training. This showed most nursing staff had received safeguarding training but overall compliance was below the trust target of 95%.

We identified concerns around safeguarding training completion for medical staff during our previous inspection in October 2021. During this inspection, we found 73% of medical staff in the IMPF division had completed adults safeguarding (level 3) training and 49% of medical staff had completed children's safeguarding (level 2) training. This showed compliance was below the trust target of 95% and there had not been any significant improvement in medical staff training compliance since the previous inspection.

We requested but did not receive any data relating to safeguarding training compliance for staff in the medical wards within the tertiary services division, therefore we have insufficient evidence to report on this.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Information on how to report adult and children's safeguarding concerns was displayed on notice boards in the areas we inspected.

The hospital had safeguarding policies available to support staff and these could be accessed on the trust intranet. Staff were aware of how they could seek advice and support from the trust-wide safeguarding team.

Cleanliness, infection control and hygiene

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

There had been six MRSA bacteraemia infections, 57 Clostridium difficile (C. diff) infections, three carbapenemase-producing enterobacterales (CPE) infection and 24 E.coli infections relating to the medical care services reported between April 2020 and March 2022. The rate of C. diff end E.coli infections was within the trust's targets.

The MRSA post Infection review panel meeting minutes for July 2021 and September 2021 showed the MRSA incidents had been reviewed to aid learning and improve staff practice around areas such as patient isolation processes and antimicrobial stewardship.

The integrated medicine and patient flow (IMPF) division 2021/22 C. diff action plan included specific actions to reduce C. diff infection rates. This included actions relating to inappropriate antimicrobial prescribing, hand hygiene compliance, patient isolation processes and ward environment and commode cleanliness. The action plan was reviewed and updated on a monthly basis.

Patients were screened for infections upon admission to the hospital. Staff used the Bristol stool chart for patients with identified C. diff risks. We looked at one investigation report for a C. diff infection from July 2021 and this showed appropriate actions had been taken to identify and manage patient risks and to minimise risk of spread of infection.

Ward areas were clean and had suitable furnishings; these were clean and well-maintained. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance. Visitors were encouraged to wash their hands.

There were separate hand wash sinks in the sluice areas and treatment rooms in each area we visited.

There was clear guidance displayed on how to minimise risk of spread of Covid-19 and we saw staff and patients adhere to social distancing guidelines across the wards. Staff followed infection control principles including the use of personal protective equipment (PPE), such as gloves, aprons and visors while delivering care.Patients identified with an infection were isolated in side rooms. We saw that appropriate signage was used to protect staff and visitors.

Equipment such as trolleys, stands and commodes were visibly clean. Staff used disinfectant wipes to clean and decontaminate equipment. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used single use disposable bed pans and cleaning equipment such as mops and buckets were appropriately stored. Clean linen was suitably stored in dedicated linen storage areas to minimise the risk of contamination.

Staff in the medical care services carried out routine audits to monitor hand hygiene compliance and the cleanliness of the environment and equipment. Audit results showed there was high levels of compliance in relation to hand hygiene compliance and the cleanliness of the environment and equipment.

The infection control audit data for January 2022 to March 2022 showed overall compliance across 24 medical care wards at this hospital was 96% (individual ward compliance ranged between 90% and 100%). The hand hygiene audit data for January 2022 to March 2022 showed overall average compliance across 24 medical care wards at this hospital was 100% (individual ward compliance ranged between 82% and 100%).

The integrated medicine and patient flow *division had an* infection prevention and control board assurance framework action plan. We looked at the February 2022 update, which showed there was on-going oversight and monitoring of progress against infection control audit findings.

Environment and equipment

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

The design of the environment followed national guidance. Access to the medical wards was secure and required key code access. Patients could reach call bells and staff responded quickly when called.

Medical care (including older people's care)

The service had suitable facilities to meet the needs of patients' families. The medical wards had day rooms that were suitably furnished. Patient visitors were restricted due to Covid-19 pandemic restrictions. However, staff told us they had facilities in place to accommodate patients' relatives (including overnight stay) if required.

Ward areas were clean and had suitable furnishings. The medical wards we inspected were well-maintained and free from clutter. The bays provided same-sex accommodation. Whilst the ward areas did not always provide a clear line of sight to patients from the nurses' station, most wards had introduced 'bay tagging' where a dedicated nurse was allocated to a bay area with cover from another nurse or healthcare assistant during their breaks.

Staff told us equipment was routinely checked and cleaned in between use. The majority of equipment (such as commodes, hoists and blood pressure monitoring machines) we saw was visibly clean and had service stickers displayed and these were within date. Single-use, sterile instruments and consumable items were stored appropriately and were within their expiry dates.

There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. Staff disposed of clinical waste safely using colour-coded waste bags, in line with national best practice guidelines.

The service had enough suitable equipment to help them to safely care for patients. Staff told us equipment needed for care and treatment was readily available and any faulty equipment could be replaced promptly. Ward staff also told us they did not have any difficulty obtaining specialist equipment, such as for pressure care or equipment for larger patients. Equipment was serviced by the hospital's estates and maintenance team under a planned preventive maintenance schedule. Staff told us they received good and timely support if a fault was reported.

The medical wards had safety boxes for oxygen, bloods, sepsis and hypoglycaemia. Emergency resuscitation equipment was available in all the areas we inspected. Staff carried out daily safety checks of specialist equipment, such as defibrillators. Staff used an electronic system to log daily emergency equipment checks and this was monitored by a central team.

The daily missed check reports for the period between October 2021 and March 2022 showed the majority of wards had few (one or less) instances where daily equipment checks had been missed. The medical care services also carried out resuscitation equipment trolley audits as part of random audits or due to concerns identified from ward accreditation visits. The audit results from 2021/22 showed wards identified as non-compliant were frequently re-audited until full compliance had been achieved.

Assessing and responding to patient risk

The service did not effectively manage risks for patients with suspected or confirmed sepsis and for patients requiring rapid tranquilisation. Whilst staff completed and updated risk assessments for most patients, risk assessments for patients admitted through the full capacity protocol were not always documented.

During the inspection, we identified significant concerns around the management of risks for patients with suspected or confirmed sepsis and for patients requiring rapid tranquilisation (emergency chemical restraint).

Following our inspection, we imposed urgent conditions under Section 31 of the Health and Social Care Act 2008 on 24 April 2022 in relation to sepsis management and rapid tranquilisation processes across the hospital.

Medical care (including older people's care)

The hospital had developed a modified sepsis in adults pathway checklist to aid staff in identifying sepsis and for staff to document the care and treatment given to patients. We looked at five records for patients with suspected or confirmed sepsis across the medical wards and found that: -

- In all five records, the modified sepsis in adults pathway checklist was present but was blank and had not been completed.
- In all five records, there was no clearly documented evidence in the daily notes to show all the sepsis 6 pathway steps had been completed by staff.
- Four of the five records included entries in the medicine administration record (MAR) and staff daily notes that showed antimicrobial treatment had commenced within one hour.
- Only one of the five records included clear daily notes entries to show blood cultures had been taken.

We found that the sepsis pathway had been initiated prior to admission to the medical wards (such as in the emergency department) for some of these patients. However, the staff we spoke with in the medical wards were not able to clearly explain why some sepsis information had been documented in the daily notes entries or why the modified sepsis in adults pathway checklist had not been completed.

Our findings showed the service was failing to identify, manage and document sepsis which meant there was a significant risk that patients could be exposed to a serious harm or risk to life, health or wellbeing. We were not assured the service had an effective system in place for managing and responding to patient risk, to ensure all service users who presented with suspected or confirmed sepsis, were cared for in a safe, effective and timely manner.

There was no sepsis audit data available specifically for the medical care services. However, the hospital carried out a monthly advancing quality alliance (AQua) sepsis audit to monitor compliance against seven sepsis clinical pathway indicators.

The AQua sepsis audit report for the period between April 2021 and December 2021 showed the trust achieved an overall year to date compliance score of 57.4%. The monthly audit compliance ranged between 41.7% and 62.6% during this period. This was significantly below the trust target of at least 75% compliance.

The audit data also showed the trust achieved the lowest (worst) year to date compliance score when compared with 13 other NHS trusts across the North West region (for whom year to date compliance ranged between 57.9% and 86%).

The monthly sepsis audit compliance scores for November 2021 (51.4%), December 2021 (41.7%) and January 2021 (39.4%) also showed there was a worsening trend in overall compliance in sepsis management across the trust. We did not see evidence of any effective action plans in place to drive improvement following the AQua audit findings.

We identified concerns around the management of patients that had received rapid tranquilisation during our previous inspection in October 2021. At that inspection, we told the trust the service must ensure that staff are made aware of and follow the trust policies relating to rapid tranquilisation and reflect national guidelines.

During this inspection, we found there had not been any significant improvements made. We found a patient on ward 6 (general medical ward) that had been administered a STAT (immediate) dose of lorazepam (sedative) at 11:50pm on 12 April 2022. Patient records showed nursing observations were completed at the time this was given to the patient. The

next set of observations were not completed until 1:54am, which was two hours and three minutes later. The notes showed the patient had a medical review at 2am that was requested by nursing staff because the patient was shaking. The medical advice was to monitor the patient. The patient was not subsequently monitored until 6am the next morning.

The trust's policy (advice and guidance in relation to the use of control and restraint within the trust) stated that 'After emergency sedation and as per guidance from (NICE NG10 2015) states side effects must be monitored and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health'.

The hospital used a 'full capacity protocol - accelerated transfers to in-patient wards.' This was implemented when the emergency department had exceeded capacity and allowed patients from the emergency department to be transferred to the hospital's inpatient wards, where there was bed availability or patients identified for discharge later that day.

The full capacity (surge) protocol was in place during the second day of our inspection. There had been 11 patients transferred to the acute medical unit (AMU) and these patients were then transferred to designated spaces across the medical wards. Patients in the AMU were located in a corridor and the AMU had a triage nurse that carried out observations on each patient on arrival to the unit.

Staff told us each patient identified for transfer as part of the protocol had a risk assessment completed in the emergency department. However, this risk assessment remained in the emergency department and was not transferred with the patient when they were moved to the medical wards.

The medical ward matrons and ward managers were involved in daily flow meetings and were well informed of the patients identified for transfer as part of the surge protocol.

The full capacity protocol listed the criteria used to determine if patients were eligible for accelerated transfers to the AMU. The inclusion criteria stated only patients with early warning score less than three (low acuity) were eligible for transfer and excluded patients on high flow oxygen, continuous infusion, end of life pathways or dementia or delirium.

The medical specialty matrons and ward managers told us they assessed each patient allocated to their wards to confirm they were eligible for transfer. They were able to verbally articulate the inclusion / exclusion criteria for surge patients and told us they applied clinical judgement when assessing patients for transfer. We did not identify any incidents of patient harm relating to surge patients over the past three months. However, a lack of formal documented assessments meant there was a potential risk of inconsistencies in individual's decision-making.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Patient records included risk assessments for venous thromboembolism (blood clots), pressure ulcers, nutritional needs, moving and handling risks, bed rails risks, risk of falls and infection control risks.

We observed six surge protocol patients across the medical wards and patient records showed they underwent the same admission assessments as routine patients on arrival to the medical wards and they received regular monitoring and observations.

Patients at high risk were placed on care pathways so they received the right level of care. We saw care pathways were in place for a number of medical conditions such as diabetes, respiratory care, heart disease and tissue viability (pressure sores) and these were completed and regularly reviewed by staff.

Medical care (including older people's care)

Staff used national early warning score system (NEWS 2) and carried out routine monitoring based on patients' individual needs so that any changes to their medical condition could be promptly identified. If a patient's health deteriorated, staff were supported with medical input and were able to contact the critical care outreach team if needed.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We found a patient at risk of self-harm in the acute medical unit (AMU) had been promptly referred and assessed by a mental health liaison psychiatrist.

Shift changes and handovers included all necessary key information to keep patients safe. Nursing and medical staff handovers took place during daily shift changes and these included discussions about patient needs and any staffing or capacity issues. Staff also took part in a number of 'safety huddles' each day where discussion around took place around patient risks.

Nurse staffing

Whilst there had been some improvements in nurse staffing levels, not all medical wards had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and staffing levels were maintained through the use of bank and agency staff.

We identified concerns around nurse staffing levels during our previous inspection in October 2021. During this inspection, we found that some improvements had been in the recruitment of new staff. However, the medical wards did not always have enough nursing and support staff to keep patients safe.

Records for nurse and healthcare assistant staff fill rates between December 2021 and March 2022 showed the majority of medical wards routinely achieved average fill rates above 85% for nursing and healthcare staff during the day and night shifts.

Shift fill rate data for December 2021 to March 2022 showed the majority of medical wards achieved average fill rates above 80% for nursing and healthcare staff during the day and night shifts. However, a number of wards reported shift fill rates below 70% for nursing or healthcare staff during this period.

The monthly average shift fill rates on the acute medical unit (AMU) during the day shift ranged between 67% and 77% for nursing staff and ranged between 72% and 88% for healthcare staff. The fill rates on nights were routinely above 85% during this period.

The monthly average fill rates for nursing staff on the acute stroke and rehab unit (wards 32 and 33) ranged between 67% and 69% on days and between 67% and 71% on nights during December 2021 to February 2022. However, this had improved during March 2022 (77% on days and 86% on night shifts). The average fill rates for healthcare staff for the day and night shifts ranged between 67% and 95% during this period.

The monthly average fill rates for healthcare staff on ward C (endocrinology) ranged between 44% and 58% on the days and between 58% and 76% on nights. The average fill rates for nursing staff for the day and night shifts ranged between 72% % and 98% during this period.

Medical care (including older people's care)

Staffing levels across the medical care services had been impacted by staff vacancies and unplanned leave or sickness due to the ongoing Covid-19 pandemic.

The hospital reported in March 2022 the medical care services had 24.41 whole time equivalent (WTE) nursing staff and 77.14 WTE healthcare assistant (HCA) vacancies. There was an on-going recruitment programme and a further 13.7 WTE HCAs had been recruited during March 2022. The hospital had an overseas nurse recruitment programme and planned to recruit 10 to 15 overseas nurses per month throughout 2022 to improve staffing levels.

We found several vacant posts across the medical wards had been recruited to, with new appointees at various stages of recruitment, induction or progressing the objective structured clinical examination (OSCE). We saw student nurses and newly qualified and overseas nurses awaiting nursing PIN numbers were supernumerary to the established staffing levels. The ward managers were also supernumerary on the wards we inspected.

The ward manager in the acute stroke and rehabilitation unit (ward 32/33) told us the staffing establishment had been assessed and recruitment for an additional 25 nurses was on-going as part of plans to evolve the service to a hyper acute stroke unit (HASU) which was planned to commence from April 2024.

Records showed the overall average sickness rate for nursing staff across the medical wards was approximately 8% between November 2021 to April 2022. However, the average nurse sickness rates for the acute medical unit (AMU), stroke unit and ward 23 and 25 (elderly care wards) ranged between 11% and 13% during this period and this was higher than trust and national average.

Staffing levels were maintained through the use of existing staff working additional hours and through the use of bank and agency staff. Records for October 2021 to April 2022 showed there was high agency and bank staff usage (approximately 137,000 bank hours and 39,000 agency hours). Records showed 48.6% of all bank and agency hours worked across all staff groups related to agency nursing and qualified bank nursing.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance, such as the safer nursing care tool. The expected and actual staffing levels were displayed on notice boards in each area we inspected, and these were updated on a daily basis. Staffing shortfalls were escalated to the daily lead matron and reviewed as part of twice daily safe staffing and acuity meetings across the medical care services.

Patient acuity was assessed on a daily basis using the 'safecare' acuity tool. However, ward managers told us it was not always possible to source additional staff required to support high acuity patients that required 1:1 care, which meant the existing staff carried out these duties leading to increased workloads. We also found a significant number of ward staff were newly qualified or new recruits, which impacted on the overall staffing skill mix.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience. There had been improvements made in the recruitment of vacant consultant posts. Staffing levels were maintained through the use of locum and agency doctors. However, shortfalls in consultant staffing in the gastroenterology and stroke specialties impacted on the delivery of care and treatment.

We identified concerns around medical staffing levels during our previous inspection in October 2021. At that inspection, we reported the tertiary services division had 10.3 whole time equivalent (WTE) medical staff vacancies. During this inspection we found some improvements had been made. The service reported there were no consultant vacancies and

one junior doctor vacancy. Consultant leave and sickness cover was supported through the use of locums and the existing team of junior doctors were able to cover the vacant junior doctor position. The service reported they had plans to develop and promote existing middle grade doctors and registrars as part of their long-term plans to improve service provision and succession planning.

At the previous inspection in October 2021, we reported the integrated medicine and patient flow (IMPF) division had 31.2 WTE vacancies. During this inspection the IMPF division reported this had improved to 23 WTE consultant vacancies. This showed there had been some improvement but the overall consultant vacancy rate was still substantial and accounted for approximately 33% of the total consultant establishment within the division.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. Cover for vacancies and medical staff absence was provided by locum and agency doctors. Managers told us most locums had long-term contracts and were familiar trust policies and processes.

The IMPF and tertiary services divisional leads reported a number of initiatives had been undertaken to improve medical staffing across the medical wards. This included on-going recruitment for vacant posts, support and development of existing middle grade doctors and registrars to progress to consultant roles and the use of advanced clinical practitioners (ACP's) and nurse consultants to support the medical staff.

The service always had a consultant on call during evenings and weekends. There was sufficient on-call consultant, registrar and junior doctor cover over a 24-hour period including cover outside of normal working hours and at weekends.

The service had a good skill mix of medical staff on each shift across most medical wards and reviewed this regularly. During the inspection, we found the cardiology, respiratory and care of the elderly specialties had sufficient consultant, registrar and junior doctor cover. Consultant led ward rounds took place on a daily basis and staff we spoke with did not highlight any concerns around medical staffing levels.

We found ward 12 (gastroenterology) had four consultants in place and two vacancies. One vacant post had been advertised since 2019 and the other since 2021. The service had a long-term locum consultant in place to provide cover for the vacant posts. Consultant led ward rounds took place seven days per week. However, the consultant vacancies meant elective activity had to be cancelled to focus on inpatient care. This adversely impacted on referral to treatment performance within this specialty. Consultant staff on the ward told us they were also responsible for covering inpatient gastroenterology referrals, which represented a substantive workload.

The acute stroke and rehabilitation unit (ward 23 and 24) had three specialist stroke consultants and daily ward rounds were carried out on weekdays. There was no specialist stroke consultant cover on site at weekends, which meant new patients admitted on weekends could be delayed for a few days awaiting specialist stroke consultant opinion and affecting patient flow. Weekend on-call cover was provided as part of the general medicine rota.

The clinical head of department for the acute medical unit (AMU) told us there was one consultant vacancy but cover was provided by a locum consultant. The clinical lead told us the junior doctors in the department had a challenging workload and they were in the process of recruiting up to four additional junior doctors to support activities, such as patient clerking.

Medical care (including older people's care)

Sickness rates for medical staff were low and reducing. Records showed the overall average sickness rate for doctors across the medical wards was approximately 1.5% between November 2021 to April 2022.

Records

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

Staff could obtain patient notes easily. When patients transferred to a new team, there were no delays in staff receiving their records. Records were stored securely across the majority of medical wards we inspected. We found only one ward (medical escalation ward) where patient records were kept on a desk and not held securely.

Staff used paper-based records. Patient records included care plans and daily observation charts as well as daily nursing and medical notes. Records included risk assessments, such as for bed rails, infection risks, falls, venous thromboembolism (VTE – blood clots), pressure care and nutrition and these were reviewed and updated on a regular basis.

Paper patient records were used for standardised nursing activities, such as daily observations and intentional rounding and these were kept at each patient's bed side. Observations were well recorded, and the observation times were at least four-hourly or dependent on the level of care needed by the patient. We also saw that patient-specific assessment records such as turn charts (pressure care), cannula charts and blood glucose assessments and foot assessments.

We looked at 29 patient records during the inspection. The risk assessments, care plans, daily notes entries and daily observation and monitoring records were mostly complete and up to date. However, we looked at fluid balance charts in eight patient records and found that information such as fluid input and output was not completed consistently and accurately in five of these records. We looked at five records for patients with sepsis and the modified sepsis pathway checklist had not been completed in all five records.

We also found that patient records were large, bulky folders that were poorly organised with no index or separators. Staff told us it was time-consuming when locating specific records within the folder. There was a long-term plan to implement an electronic patient record system across the trust within the next two years.

There was an annual trust-wide record keeping and legibility audit that involved a sample of at least 20 nursing and medical staff record entries from each ward. The most recent audit (April 2021) showed compliance in the medical wards ranged between 57% and 72%, compared with an overall trust average of 68% compliance. Staff told us a sample of four to 10 patient records were also reviewed for accuracy and completeness as part of routine ward accreditation assessments.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. Patients did not always receive their medicines as prescribed.

We looked at the medicine administration record (MAR) charts for 19 patients across eight medical wards. We saw evidence on ward 6 and the acute medical unit (AMU) where patients had missed doses of IV and oral antibiotics, antihypertensive medicines and antidepressants.

Medical care (including older people's care)

Staff did not always complete medicines records accurately or keep them up-to-date. We found on ward 6 that some medicines administration records did not match the information in care summaries when medicines had been prescribed and administered so we could not be sure what the patient had received. There is a risk that medicines may be given twice if not documented properly.

Pharmacy staff reviewed patients' medicines regularly and provided specific advice to staff. Pharmacists had reviewed and annotated prescription charts, but we saw examples when this information was not followed by nursing staff. One patient on the AMU was missing one of their three daily doses for seven days despite the pharmacist note.

When patients were prescribed antibiotics, the indication and stop dates were not always noted. Some weight specific doses, specifically for treating sepsis, had been administered without a record of the patient's weight on three occasions (Ward C and AMU). One time-specific IV antibiotic had been administered late on two occasions due to lack of stock on ward C (endocrinology).

We also saw an error where the wrong quantity of antifungal medicine had been administered (10ml instead of 1ml) on six occasions on ward C on 13 and 14 April 2022. This had been corrected by the pharmacist, but no error report had been completed.

We looked at one patient's records on the AMU where the alcohol liaison team had recommended the patient commence the Clinical Institute Withdrawal Assessment for Alcohol (CIWAA) pathway for alcohol withdrawal, but this had not been started and treatment had not been given.

We saw that medicines that required storage at temperatures between 2ºC and 8ºC were kept in medicine fridges and staff monitored fridge and clinic room temperatures on a daily basis. We found a number of instances where the fridge and room temperature logs had exceeded recommended temperature ranges (2-8°C for medicine fridges and above 25°C for clinic rooms) on multiple occasions during April 2022 in five of the medical wards we inspected.

The temperature logs included a section for staff to record actions taken if temperatures exceeded recommended ranges. The staff we spoke with told us they would notify the pharmacy team or maintenance team where medicine fridge or treatment room temperatures exceeded the maximum temperature range. However, the relevant section of the log sheets was not always completed in the log sheets we looked at and did not clearly show if staff had escalated to the maintenance or pharmacy teams.

The fridge temperature log in ward 23 (elderly care) had exceeded 8°C on six occasions during April 2022, the log sheets showed this had been reported on three occasions only. The room temperature log had also exceeded 25°C on five occasions and the logs sheets did not contain any evidence to show this had been escalated.

The room temperature log for ward C (endocrinology) showed maximum recorded temperatures ranged between 25°C and 28°C each day from 1 April 2022 to 19 April 2022. The ward manager had taken actions and escalated this to the hospital's maintenance team, however, this had not been documented on the room temperature log sheets.

Medicines, including controlled drugs, were stored securely. Staff carried out daily checks on controlled drugs and medicine stocks to ensure that medicines were reconciled correctly. We looked at a sample of routine medicines and controlled drugs and found the stock levels were correct, and the controlled drug registers were completed correctly. Medicines were returned to the pharmacy team for safe disposal.

The service carried out a number of medicines management audits to monitor staff compliance with trust policies. Audit records we looked at showed staff compliance was mixed and did not always meet required standards. Medicines audit findings and progress on actions were reviewed as part of routine divisional clinical effectiveness committee meetings.

The prescribing audit 'a zero tolerance approach to unsafe prescribing' (November 2021) included a review of 200 prescriptions across the IMPF division. The overall compliance achieved across the division was 86%, which had improved since the last audit in 2020 (80%). The audit also showed the IMPF division achieved 70% compliance for *PRN* (pro re nata) or 'when required' medicine prescriptions and 89% for fluids prescription records.

The audit identified poor compliance in three indicators; legible printed name next to signature (63%) patient allergy status present (36%) and stop date for cancelled items (30%). There was an action plan that included actions such as shared learning and further training with staff and to use stickers for recording staff identity information. The trust also planned to launch an electronic prescribing process during June 2022 to improve staff compliance with medicines management processes.

The omissions and delay of medicines audit (November 2021) showed the medical care services achieved poor compliance for correctly recorded medicine omissions. The IMPF division achieved 59% compliance in October 2021. However, this had improved from 29% compliance in March 2021. The tertiary services division achieved 45% compliance in October 2021, which had improved from 17% compliance in March 2021.

Each medical ward had an action plan in place to improve compliance. This included specific actions such as shared learning and to raise staff awareness in the use of omission stickers and how to access emergency medicines during out of hours service.

The monthly medicine reconciliation audit for the IMPF division showed the proportion of drug histories completed for patients admitted during weekdays ranged between 50% and 67% during November 2021 and April 2022. The proportion of drug histories completed during weekends ranged between 5% and 13% during this period, indicating poor compliance in documenting drug histories. There was an action plan in place to improve compliance. However, the audit results showed there had not been any significant improvement in compliance during this period.

The antimicrobial stewardship audit included monitoring of antimicrobial treatment in line with formulary requirements. Overall compliance between June 2021 and December 2021 ranged between 91% and 100% across the IMPF and tertiary services divisions, indicating high levels of staff compliance. Audit findings and staff compliance was monitored as part of antimicrobial stewardship committee meetings, which were held every three months.

Incidents

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

We identified concerns around the management of incidents during our previous inspection in October 2021. At the previous inspection, we reported that incidents were not always reported and investigated in a timely manner, which meant there was delayed learning from incidents which could impact on the safety of other patients.

During this inspection, we found significant improvements had been made in incident management processes.

Medical care (including older people's care)

The trust had updated the management of incidents policy and standard operating procedure following our previous inspection. The IMPF and tertiary services divisions had also introduced daily reporting and new incidents were reviewed by divisional governance leads to check they had been appropriately graded depending on the severity of the incident.

There was a daily incident meeting to review serious incidents or incidents identified as moderate harm (including serious incidents). The divisional leads received daily and weekly incident reports detailing open and breached incidents and investigation reports. There was a weekly meeting to review closed incidents graded as low or no harm to check they had been graded correctly.

The management of incidents policy defined investigation timelines for incidents. All incidents reported as moderate or above harm required completion of a 72-hour rapid review investigation report and the divisional managers received daily notifications of new incidents requiring rapid review. The policy defined breached incidents as those that had not been investigated and resolved within 20 working days for low harm and moderate harm incidents and within 50 days for serious incidents.

Divisional and trust leads were notified daily if any serious incidents were reported. Serious incidents were investigated by a multidisciplinary team of trained staff with the appropriate level of seniority, such as clinical heads of department and matrons.

Trust data for 25 April 2022 showed the IMPF division had 683 open incidents and 137 of these had breached trust timelines for completion (of which 37 related to ongoing investigations). The tertiary services division had 92 open and 13 breached incidents (of which two related to ongoing investigations). The majority of breached incidents were graded as no or low harm.

Incidents were reviewed as part of routine ward meetings, divisional quality and clinical effectiveness meetings and divisional board meetings to monitor performance and to identify learning and improvement.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed during daily ‘safety huddles’ and routine staff meetings so shared learning could take place. Learning from incidents was also shared through hospital-wide alerts and newsletters.

The service had no never events on any medical wards during the past 12 months. Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

Staff reported serious incidents clearly and in line with trust policy. During the 12 months from 17 March 2021 to 16 March 2022 the trust reported 11 STEIS serious incidents in relation to the medical care services at this hospital. Seven of these related to pressure ulcers, three related to suboptimal care of the deteriorating patient and one incident was in relation to slips, trips and falls. The hospital reported 7,300 NRLS incidents in relation to the medical care services during this period and 97% of these were graded as low or no harm.

Medical care (including older people's care)

We looked at three serious incident investigations completed during 2021. These contained appropriate information, action plans and evidence of learning and improvement. There was evidence of comprehensive investigations having been undertaken with root cause analysis and chronology (timeline of events) recorded. The incident reports detailed the involvement and support provided for staff involved in the incident as well as support for patients and relatives (such as duty of candour principles). Action plans had lead responsibilities and completion due dates recorded.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Records showed the medical care services had achieved 100% compliance against duty of candour standards over the past 12 months.

Patient deaths were reviewed by individual consultants within their specialty area. These were also presented and reviewed at routine quality effectiveness and mortality meetings in the IMPF division and mortality and morbidity committee meetings in the tertiary services division. We looked at recent meeting minutes and these showed patient deaths were reviewed and discussed to identify good practice and learning through improvement actions.

Medical staff could access a learning from deaths digital tool that was used for retrospective review of the case records of deceased patients, including structured judgement reviews. Staff spoke positively about the digital tool and told us it enabled staff to access up to date information about patient deaths and was used to inform mortality and morbidity meetings.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance in relation to sepsis management and rapid tranquilisation processes. Staff protected the rights of patients subject to the Mental Health Act 1983.

The medical care service had policies to plan and deliver care according to best practice and national guidance. Clinical guidelines and pathways were based on national guidance, such as from The National Institute for Health and Care Excellence (N*ICE*). We reviewed care pathways for a number of medical conditions, including stroke, diabetes, heart disease, acute kidney injury and pneumonia and found these were based on best practice guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff sought advice and support from mental health liaison specialists when providing care and treatment for patients with mental ill health.

Patients receiving acute non-invasive ventilation (NIV) were treated in a designated respiratory ward (ward 10), in line with British Thoracic Society (BTS) quality standards for acute non-invasive ventilation in adults (April 2018)

The trust had developed a modified sepsis in adults pathway checklist and form for staff to follow. This was based on the national sepsis six pathway (UK Sepsis Trust Guidance) and NICE guideline NG51: Sepsis: recognition, diagnosis and early management (2016). However, the trust's pathway did not clearly state that suspected or confirmed sepsis must be treated with all sepsis six treatments within one hour.

The trust did not have a specific policy or procedure in relation to the management of sepsis, apart from the modified sepsis pathway. However, we saw evidence following the inspection that a draft policy had been written, based on national guidelines such as NICE NG51. We found during the inspection that staff practice did not always reflect trust policy and national guidelines around sepsis management.

The trust's policy for use of restraint made reference to relevant national guidance, such as NICE NG10 (2015). However, we found staff practice did not reflect the trust policy or the national guidance in relation to the timely monitoring and observation of rapid tranquilisation patients.

Findings from clinical audits were reviewed during monthly divisional board meetings and any changes to guidance and the impact that it would have on their practice was discussed.

Staff told us policies and procedures reflected current guidelines and were easily accessible through the trust's intranet. We looked at a selection of the policies and procedures and these were up to date and referenced national guidelines.

The medical care services participated in both national and local clinical audits. The trust's annual audit work plan showed the integrated medicine and patient flow (IMPF) division participated in 64 clinical audits, of which 97% were on track for completion. The tertiary services division participated in 20 clinical audits, of which 100% were on track for completion.

Findings from clinical audits were reviewed during routine divisional clinical effectiveness meetings and any changes to guidance and the impact that it would have on their practice was discussed.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs. However, staff did not always fully and accurately complete patients' fluid and nutrition charts.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition; the *Malnutrition* Universal Screening Tool (*MUST*). The patient records we looked at showed patients were assessed on admission and routinely updated. Patients' nutrition and hydration needs were also monitored as part of intentional rounding observations, which took place at least every four hours.

Where patients were identified as at risk, staff completed patients' fluid and nutrition charts. However, these were not always fully and accurately completed. We looked at fluid balance charts in eight patient records and found that information such as fluid input and output was not completed consistently and accurately in five of these records (of which three were from the acute medical unit (AMU)).

The bowel, nutrition and hydration audit (March 2022) also reflected our findings and showed compliance in fluid balance documentation was 53% in the AMU and 70% in the acute stroke and rehabilitation unit, compared with overall average trust compliance of 88%.

Specialist support from staff such as dietitians was available for patients who needed it. The records we looked at showed that there was regular dietitian involvement with patients that were identified as being at risk. Patients with specific dietary needs (such as diabetic patients) were identified and routinely monitored by staff.

Patients with difficulties eating and drinking were placed on special diets and staff told us patients could also be provided with finger foods and snacks. Patients told us they were offered a choice of food and drink and they spoke positively about the quality of the food offered. Patients ordered their meals electronically, with support from staff if required. Optional menus were available for patients with specific requirements. We observed that protected meal times were in place and saw patients being supported to eat and drink. Drinks were readily available and were in easy reach of patients.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it. Patients told us staff gave them pain relief medication when needed and their pain symptoms were managed appropriately. Acute pain symptoms were managed by the medical care consultants.

Staff prescribed, administered and recorded pain relief accurately. The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements. Whilst most clinical audit outcomes were comparable to expected national standards, the service performed worse than expected in the sentinel stroke national audit programme.

The medical care service participated in the sentinel stroke national audit programme (SSNAP) which was updated every three months. On a scale of A-E, where A is best, the hospital achieved an overall SSNAP level of grade D in the latest audit (October to December 2021), This was worse than the overall results of the two previous reporting periods; April to June 2021 (grade C) and July to September 2021 (grade B).

The latest audit results (October to December 2021) also showed the hospital achieved grade D for two indicators (thrombolysis and physiotherapy) and grade E for two indicators (stroke unit and speech and language therapy). Planned actions to improve SSNAP audit outcomes included improvements in speech and language therapist and nurse staffing and to improve provision of stroke specialist consultants on weekends.

The lung cancer audit (2020) results showed the hospital performed better or within expected range for four of the five indicators. The hospital also performed within expected levels across the indicators in the myocardial ischaemia national audit project (MINAP) audits for 2019/20 and 2020/21 and the national audit for care at the end of life (NACEL) 2019.

Medical care (including older people's care)

The ‘strategic work programme’ care pathways audit (February 2022) showed the services achieved good levels of overall compliance in relation to the chronic obstructive pulmonary disease (COPD) pathway (77%). The service had a respiratory improvement programme in place and action plans were progressed and routinely reviewed by the clinical audit leads.

The trust’s internal pathways audit (February 2022) also showed the services achieved good levels of overall compliance in relation to the acute kidney injury pathway (76%). However, overall compliance relating to the heart failure pathway was 32%.

Hospital episode statistics data for the period between August 2020 and July 2021 showed patients in gastroenterology had a higher than expected risk of readmission for elective admissions. For non-elective admissions, patients in cardiology had a higher than expected risk of readmission for non-elective admissions. The risk of readmission for elective and non-elective admissions for medical oncology, clinical haematology general medicine and respiratory medicine were lower (better) than expected during this period.

The divisional triumvirate leads for the integrated medicine and patient flow (IMPF) and tertiary services division told us they did not have any specific concerns in relation to patient readmissions and readmission rates were reviewed on a regular basis.

Competent staff

The service made sure staff were competent for their roles. However, we received limited assurance around competency based training for staff in relation to sepsis management and the use of rapid tranquilisation. The number of staff that had completed their appraisals did not meet trust targets.

Staff were mostly experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Managers made sure all bank and agency staff had a full induction and understood the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. The triumvirate leads for the tertiary services division reported overall appraisal compliance was approximately 75%. The integrated medicine and patient flow (IMPF) divisional board meeting minutes (March 2022) stated medical appraisal compliance was 70.7%. This showed that most staff across the medical care service had undergone appraisal. However, compliance was below the trust’s internal target of 95%.

The clinical educators based in the acute medical unit (AMU) and the stroke unit supported the learning and development needs of staff. The ward managers and other senior staff took on the responsibilities for staff learning and development in the medical wards that did not have dedicated clinical educators in place.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Most staff we spoke with told us they routinely received competency-based training in their specialty area and felt confident to do their role.

Staff in the medical wards received role-specific training in areas such as blood transfusion, medicines management awareness, mental capacity act and record keeping. Records showed overall role-specific training compliance in the IMPF division was 80% for nursing and support staff (and 86% for nursing staff only). Nursing staff on ward 10 (respiratory) told us they received additional optional e-learning in non-invasive ventilation (NIV) training.

The nursing and care staff also completed the 'recognise and act' competency training which included topics such as managing the deteriorating patient, acute kidney injury and sepsis management. Records showed overall 'recognise and act' training compliance in the IMPF division was 82% for nursing and support staff (and 88% for nursing staff only). We received limited assurance around training in sepsis management for medical staff across the medical services.

We identified concerns around the management of patients that had received rapid tranquilisation. We received limited assurance around staff competencies or training relating to rapid tranquilisation or the use of chemical restraint. The staff we spoke with were aware of policies and procedures but were unclear about formal training or competencies in relation to rapid tranquilisation.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Junior nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management. Medical staff told us they attended weekly training days and received role-specific training as part of their continual professional development (CPD).

Managers made sure staff received any specialist training for their role. The practice development nurse on the stroke unit was carried out 1:1 training where needed, as well as focussing on specific topics such as national early warning scores, observations documentation training, pressure care and learning from incidents for all nursing staff.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.

The ward staff told us they had a good relationship with consultants and ward-based doctors. We saw there was effective team working and communication between the theatre teams. Patients had their care pathway reviewed by relevant consultants.

Staff worked across health care disciplines and with other agencies when required to care for patients. Specialty multidisciplinary (MDT) meetings took place on a weekly basis with input from medical and nursing staff as well as staff within the trust or external hospitals where patients received care and treatment from more than one healthcare organisation.

The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

The ward staff told us they received good support from pharmacists, dietitians, physiotherapists, occupational therapists as well as diagnostic support such as for x-rays and scans.

Medical care (including older people's care)

Seven-day services

Key services were available seven days a week to support timely patient care across most medical wards. However, stroke specialist consultant and speech and language therapy support was not always available on weekends in the stroke unit.

Consultant led daily ward rounds took place across most medical wards, including weekends. Patients were reviewed by consultants depending on the care pathway. There was sufficient out-of-hours medical cover provided to patients in the medical wards by junior and middle grade doctors as well as on-site and on-call consultant cover.

There was on-site consultant presence across most medical specialties on weekends along with on-call cover. However, the acute stroke and rehabilitation unit (wards 32 and 33) did not have on-site stroke specialist consultants on weekends. Patients were routinely reviewed by junior and middle grade doctors on weekends with on-call registrar and consultant support available if needed.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests (such as microbiology or X-rays) 24 hours a day, seven days a week.

Ward staff on the majority of medical wards told us physiotherapy and occupational therapy services were available during weekdays with on-call provision during out of hours service and on weekends.

Pharmacy support was available during weekdays with on-call support during out of hours service and on weekends. The pharmacy (dispensary) service was also open for a limited number of hours during the day on Saturdays and Sundays.

Ward staff reported that specialist teams (such as diabetes or tissue viability) were available during weekdays with on-call support on weekends. The stroke unit did not have a dedicated speech and language therapist (SALT) due to on-going recruitment issues, which meant there was no SALT cover on weekends in the unit.

The ward staff told us they received good support outside normal working hours and at weekends.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards. Information was displayed on notice boards and in information leaflets that were readily available for patients. There was signage and posters in place promoting safe hand hygiene practices and side rooms had appropriate signage to make staff and patients aware of any potential risks.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Health promotion was included as part of the ward admission process. Patients identified with weight concerns were referred to dietitians for advice and support. Patients with addiction to alcohol and drugs were offered treatment and provided with support from specialist hospital-wide liaison teams.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Medical care (including older people's care)

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Staff were clear about how they sought informed verbal consent before providing care. Patient records we looked at showed verbal and written consent was sought from patients undergoing treatment or procedures (such as chest drain procedures).

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) as part of their adult safeguarding training. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice. Staff routinely sought advice and support from the trust-wide safeguarding team.

We identified concerns around mental capacity assessment processes during our previous inspection in October 2021. At the previous inspection, we reported that staff did not always carry out an appropriate assessment of a patient's capacity to consent to specific decisions about their care and treatment. We found improvements had been made during this inspection.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us they completed mental capacity assessments if they identified a patient that lacked the capacity to make their own decisions and assessments were completed prior to making specific decisions about a patient's care (such as DoLS decisions). We looked at five patient records where patients had DoLS in place. In all cases a mental capacity assessment had been completed appropriately.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. The five patient records we looked at showed all DoLS applications were current and appropriate for the patient and records were completed accurately. The patient records also showed there had been regular assessments undertaken by the trust-wide adult safeguarding team where urgent DoLS orders had expired to determine whether the DoLS order was still appropriate for the patient.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. The five patient records we reviewed also included a completed best-interest decision-making form. However, in two records in the acute medical unit (AMU), the best-interest decision-making form had only been completed by the individual member of staff (registered nurse). There was no record in the best-interest form or the daily notes entries to show who else had been involved in the best-interest decision-making process (e.g. multidisciplinary team and patient representatives) and there was no record to show the discussion or outcome of the best-interest decision-making meeting.

The other three patient records were reviewed on ward 23 (care of the elderly) and ward C (endocrinology) and these included a well-documented best interest form, which included detailed information around input from multidisciplinary teams and patient representatives' involvement and clearly documented outcomes of the meeting.

We looked at 'do not attempt cardiopulmonary resuscitation (DNACPR) orders' in 11 patient records and reasons for DNACPR order were documented and relevant for the patient. The records we looked at had been completed appropriately by medical staff with involvement from the patient or their relatives or carers. Where patients lacked capacity to make their own decisions, staff had completed mental capacity assessments and DNACPR records documented discussions with patient's relatives or carers.

Medical care (including older people's care)

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The trust-wide safeguarding team carried out a monthly audit, based on a sample of at least 40 patient records to monitor compliance against best-interest decision-making, DoLS care planning and the timely review of capacity assessments and restrictions. Audit results for the period between December 2020 and February 2022 showed compliance ranged between 80% and 98% indicating good levels of staff compliance across the audit standards.

The trust-wide safeguarding team also carried out a monthly audit / survey of a selection of staff across the wards to gauge their understanding of the five principles of the Mental Capacity Act. The results between June 2021 and February 2022 showed overall compliance for February 2022 was 75% compared with 66% compliance in June 2021, indicating there had been an improving trend in staff awareness and understanding of the five principles of the Mental Capacity Act.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, and took account of their individual needs. However, patients admitted as part of the full capacity protocol did not always have their privacy and dignity maintained whilst awaiting an inpatient bed.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We saw that patients were treated with dignity, compassion and empathy.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Patients said staff treated them well and with kindness. We spoke with seven patients during the inspection. They all told us they thought staff were friendly and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included: ‘lovely staff, very dedicated’, ‘staff are amazing’, and ‘staff very good, can’t do enough for you’.

Staff followed policy to keep patient care and treatment confidential. We saw that bed curtains were drawn when providing care and treatment and we saw nursing and medical staff speak with patients in private to maintain confidentiality.

We also spoke with four additional patients that had been transferred to the medical wards as part of the surge protocol. We saw patients were in chairs or trollies in designated spaces in the ward corridor or in the bay areas, so their privacy and dignity could not always be maintained. Staff told us they would temporarily move the patient to a side room if they required privacy. We did not see any privacy screens in place across the wards with surge protocol patients. The ward managers told us these had been ordered but had not yet been put in place.

Patients could give feedback on the service and their treatment and staff supported them to do this. The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between November 2021 and April 2022 showed the medical wards at this hospital achieved monthly satisfaction scores ranging between of 94% and 100% (based on a monthly response rate ranging between 26% and 38% during this period) This indicated the majority of patients who responded were positive about recommending the hospital's medical wards to friends and family.

Staff also collated feedback from patients through compliments and 'thank you' cards and letters. The medical care wards had received 107 compliments and 426 'thank you' responses from patients and their relatives between November 2021 and April 2022.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

We observed staff providing reassurance and comfort to patients. Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties. Patients told us the staff were calm and reassuring. One patient told us they had raised concerns about noise from another patient on the ward. The staff provided ear plugs and an eye mask for the patient and moved the patient to a side room to help them sleep better.

Staff demonstrated empathy when having difficult conversations with patients and told us they would utilise private rooms (such as the relatives' rooms) when delivering bad news to patients or their relatives.

Patients or their relatives could be referred for access to counselling and psychological support if required. A multi-faith chaplaincy service was available for spiritual or religious support to patients of all faiths and beliefs. Staff told us they could contact the hospital's palliative (end of life care) team for support and advice during bereavement.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed staff speaking with patients clearly in a way they could understand.

Medical care (including older people's care)

Staff supported patients to make informed decisions about their care. We spoke with seven patients. They told us the nursing and medical staff fully explained the care and treatment options to them and allowed them to make informed decisions. Patient comments included “fantastic communication, fully understand treatment plan with medical doctors’ and ‘the doctors, nurses and physiotherapists have good communication and explain clearly’.

The hospital had restricted visiting due to the Covid-19 pandemic; however staff told us they routinely discussed patients’ care with their relatives. Patients could keep in contact with their relatives through the use of phones and staff told us they provided assistance to patients who wished to speak with their relatives. We spoke with a patient whose phone had run out of battery. Staff provided support to enable the patient to contact their family.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so that they met the needs of the local population. There were daily meetings with the bed management team so patient flow could be monitored and maintained and to identify and resolve any issues relating to the admission or discharge of patients. Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues and there was daily involvement with flow coordinators, ward managers and matrons to address these risks. The services had a ‘matron of the day’ that oversaw and escalated staffing and bed capacity issues on a daily basis.

Facilities and premises were appropriate for the services being delivered. Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The areas we inspected were compliant with same-sex accommodation guidelines. The hospital reported there had been mixed sex breaches in the frailty assessment unit due to bed capacity issues.

There was a clear escalation process and guidance for staff to manage patients during busy periods. The hospital was extremely challenged due to capacity issues within the emergency department and was operating at level four (highest level) of the NHS operational pressures escalation levels (OPEL) framework at the time of the inspection.

Overall bed occupancy rates across the hospital had been consistently higher than 90% between February 2022 and April 2022. This was reflected in the medical wards we inspected as most beds were occupied.

The hospital’s ‘full capacity protocol - accelerated transfers to in-patient wards’ was implemented when the emergency department had exceeded capacity. The trust reported the full capacity (surge) protocol had been enacted on 24 separate occasions between February 2022 and April 2022. The surge protocol had an impact on patient experience, although staff were clear these patients were safer in the medical wards than if they had remained in the emergency department.

Medical care (including older people's care)

The hospital launched a 10-bedded frailty assessment unit (FAU) in December 2021 as a rapid response to escalation needs within the emergency department. The unit was led by a care of the older person physician and a senior advanced care practitioner, with dedicated therapies and *integrated assessment* team support. The trust reported that since the launch same day length of stay had significantly improved and was above the national targets and the readmission rates had decreased.

The service had reconfigured an adolescent ward two weeks prior to our inspection for use as a seven-bedded inpatient escalation ward for accommodating medical patients. The ward had seven single rooms and was staffed with two nurses, with medical on-call support.

The medical care services also opened a new 24-bedded discharge to assess unit (ward 4) in April 2022 for accommodating patients who did not meet the criteria to reside across the trust.

The service relieved pressure on other departments when they could treat patients in a day. The service had commenced a trial to operate a general practitioner assessment unit (GPAU) on 5 April 2022. The purpose of the unit was to allow direct assessment for GP referrals to acute medicine and to reduce emergency department attendance and admission avoidance. The GPAU was located in the acute medical unit (AMU) and had capacity for two bed spaces and four chairs. The GPAU operated from 10am until 9pm and was staffed with a nurse, a healthcare assistant and a registrar. The two bed spaces were converted to AMU inpatient beds overnight and patients were discharged or transferred out the following morning to allow use for GPAU assessments.

The trust reported that 55% of GP referrals had been assessed in this area and the IMPF division was undertaking a review on how to expand the model to increase the number of patients assessed through the pathway. Staff told us they could see up to 17 patients per day and most patients were discharged following their assessment. Patients requiring further treatment were admitted as inpatients to the AMU.

The short stay unit (SSU) was located next to the AMU and could accommodate 35 patients for up to 72 hours. There was a business case planned to combine the AMU, SSU and GPAU into a hub area.

The service had systems to help care for patients in need of additional support or specialist intervention. The haematology services worked in partnership with a neighbouring trust and consultants from this hospital were co-located across the Blackpool and Preston regions.

The tertiary services division reported an additional modular catheterisation laboratory (cath lab) had recently been installed to improve capacity to five cath labs, which operated during weekdays.

The stroke and rehabilitation unit (wards 32 and 33) were working towards becoming a hyper-acute stroke unit (HASU) and planned recruitment of nurses and medical staff was on-going. The trust reported they were in the process of implementing improvements to the stroke services and aimed to deliver full HASU services from April 2024 onwards. As part of the implementation process, the services were in the process of recruiting additional therapy, nursing and non-medical consultant posts and planned to install a purpose built ambulatory unit for ambulatory stroke patients by October 2022.

Medical care (including older people's care)

Meeting people's individual needs

The service was inclusive and took account of most patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. However, this was not always documented clearly in patient records. Patients admitted as part of the full capacity protocol did not always receive clear information whilst awaiting an inpatient bed.

The service had information leaflets available in languages spoken by the patients and local communities. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

We spoke with four patients that had been transferred to the medical wards as part of the full capacity (surge) protocol. They told us they had not been given any written information explaining the full capacity protocol but staff had verbally explained the reasons for moving them to the wards. Three patients told us they had not been given clear information on how long they would expect to wait for an inpatient bed or clear information relating to their ongoing care and treatment.

Wards were designed to meet the needs of patients living with dementia. We saw a number of medical wards had dementia friendly (pictorial) signage and colour coded areas. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The care of the elderly wards had day rooms with reminiscence themes and utilised various interactive tools for distraction techniques and stimulus engagement for patients living with dementia.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using hospital passports, detailing their preferences. We looked at three patient records for patients living with dementia and found two of these included the 'paint me a picture' hospital passport. The remaining patient record did not include the hospital passport; however, there was some evidence of person-centred care planning in the daily notes entries.

We looked at one patient record for a patient with a learning disability on ward 23 (elderly care ward). The record contained a hospital passport detailing patient preferences and a care plan encompassing daily living, hygiene and mobility. There was no specific care plan for learning disabilities in the patient record or in the daily notes entries. The ward manager was able to verbally describe reasonable adjustments in place for this patient such as allowing the patient's relative to attend the ward daily and for the patient to be accompanied by a relative when receiving certain care and treatment. However, this was not clearly recorded in the patient notes, which could lead to inconsistent delivery of care.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were worse than national standards across most medical specialties. There was a worsening trend in performance for patient wait times and delayed discharges. Patients experienced frequent bed moves due to infection risks and bed capacity issues.

We identified concerns around performance against referral to treatment waiting times and the arrangements to admit, treat and discharge patients as part of our previous inspection in October 2021. We found that significant improvements had not been made during this inspection.

Referral to treatment (RTT)

Medical care (including older people's care)

NHS data for overall 18 week referral to treatment performance from January 2022 showed the trust was ranked in the top 25% of the country and performed better than the regional and national averages (73%).

Trust data between October 2021 and April 2022 for patients that received treatment less than 18 weeks from referral to treatment showed four out of six medical specialties we looked at had either remained the same or deteriorated: -

- The average monthly compliance for the gastroenterology speciality ranged between 44% and 47%. There had been no significant improvement or deterioration in overall performance during this period.
- The average monthly compliance for the rheumatology speciality ranged between 47% and 57%. There was a worsening trend in performance each month (56% in October 2021 and 44% in April 2022).
- The average monthly compliance for the respiratory speciality ranged between 56% and 91%. There was a worsening trend in performance each month (91% in October 2021 and 56% in April 2022).
- The average monthly compliance for the cardiology speciality ranged between 69% and 74%. There had been no significant improvement or deterioration in overall performance during this period.
- The elderly medicine and dermatology specialty services achieved average compliance over 90% during this period. Average compliance for April 2022 was; dermatology (97%) and elderly medicine (94%).

Referral to treatment performance for elective patients was monitored on a weekly basis at divisional and trust level through patient tracking lists (PTL's). There was also a trust-wide elective recovery action plan in place.

The gastroenterology services reported RTT performance had been impacted by consultant vacancies and lack of endoscopy capacity which had led to delays in patient treatment. Remedial actions planned to improve performance included outsourcing outpatient activity to increase consultant capacity and approval to install an additional modular endoscopy unit.

The respiratory services reported RTT compliance had reduced as a result of increased staff sickness due to the Covid-19 pandemic and the need to prioritise clinicians to support the wards and emergency department with the ongoing capacity and winter pressures. Remedial actions to improve performance included reinstating all clinics to return to expected capacity levels, change to consultant job plans to align clinics and create more clinic slots and the recruitment of two additional locum consultants to support the service.

The rheumatology service had a backlog for new and follow up patients resulting from job plan changes that resulted in reduced capacity and consultant sickness due to the Covid-19 pandemic. Improvement actions included a review of clinics as part of the waiting list initiative (WLI), plans to outsource some services to external virtual health providers and the recruitment of additional consultants and a nurse consultant to improve capacity.

Harm Reviews

At the previous inspection in October 2021, we found the trust did not have effective systems to identify and reprioritise patients on waiting lists based on changes to their presenting risks.

We found during this inspection that improvements had been made. A harms review assessment was carried out in November 2021 for all patients waiting over 52 weeks from referral to treatment. The review identified four medical patients on the rheumatology specialty waiting list who required assessment. All four patients had been reviewed and booked in clinic and there was no patient harm identified for these patients.

The trust reported in April 2022 that three rheumatology specialty patients had been identified as waiting over 78 weeks from referral to treatment and were pending a review assessment by staff.

Decision to Admit Performance

Most patients were admitted for medical treatment through the accident and emergency department. Patients referred by their general practitioner (GP) were directly admitted to the acute medical unit (AMU) where a GP assessment area had been launched in April 2022.

The average time from the decision to admit to departure (for AMU admissions) had consistently increased during each month between November 2021 (869 minutes) and April 2022 (1,148 minutes) demonstrating there was a worsening trend in the time taken to admit patients from the emergency department to the AMU.

The clinical head of department for the AMU told us four AMU consultants were based in the emergency department as part of an in-reach model to facilitate the timely admission of patients to the unit.

Bed Moves

Trust data showed that in the past six months, 917 (out of total of 4,225) patients experienced one bed move, 452 patients experienced two bed moves and 394 patients experienced three or more bed moves during their hospital stay.

Staff moved patients between wards at night; 16% of the total bed moves over the past six months occurred at night (between the hours of 8pm and 8am).

The trust reported that over the past six months, there had been higher numbers of patient bed moves due to moving patients to or from designated cohort or isolation areas when their Covid-19 infection status changed. The infection control guidance on the management of Covid-19 had been revised in May 2022 to support the return of patients to specialty inpatient beds and this was expected to reduce numbers of bed moves.

We found patients admitted to the medical wards as part of the full capacity (surge) protocol experienced additional bed moves. These patients were initially transferred from the emergency department to the acute medical unit (AMU) and then to a further medical ward.

During the inspection, four of the six patients we reviewed that were admitted to the medical wards as part of the full capacity (surge) protocol had not been transferred to the speciality ward relevant to their condition. This included three respiratory and one gastroenterology patient that were transferred to designated surge spaces in the general medical and care of the elderly wards. This meant they were likely to experience further bed moves when transferred to the appropriate specialty ward.

Full Capacity (Surge) protocol

The full capacity (surge) protocol was in place during the second day of our inspection. The protocol was initiated at a flow meeting attended by bed management coordinators and matrons and managers across the hospital. We found 11 patients had been transferred to the acute medical unit (AMU) from the emergency department from 8:15am onwards and most of these patients had been transferred to designated spaces across the medical wards by 9:30am.

The trust had allocated up to one surge patient space per ward across 13 medical wards. We observed six of these patients across the medical wards we inspected and they were located in a chair in a bay area or in the ward corridor near the nurses' station.

The ward staff told us surge patients could wait between three to four hours upon arrival for an inpatient bed to become available. The patients we saw had waited up to three hours and had not yet been allocated an inpatient bed. Staff told us they escalated to the bed management team if patients had not been allocated a bed after 1pm as part of the daily flow meetings.

Staff told us there had been instances where patients waited up to a maximum of 10 hours before they were allocated a bed. If a bed was not available on the ward, the surge patient would be transferred to another ward.

We saw that patients were routinely monitored by ward staff to monitor clinical and patient safety risks. However, we found these patients experienced long waits before they were placed in inpatient beds, which impacted on their general well-being and patient experience. Three of the patients we spoke with had also experienced long waits whilst in the emergency department.

The electronic bed management system allowed staff to track the wards the surge pathway patients had been transferred to. Managers told us they did not routinely collate information around the length of time patients waited whilst in the surge spaces. The trust reported they planned to launch a new internal patient tracker system in June 2022 with the capability to monitor patient movement in a clearer and more concise manner.

Patient Length of Stay

Managers and staff worked to make sure patients did not stay longer than they needed to. Patient length of stay was affected by delayed transfers of care (patients that were medically optimised for discharge but were awaiting a package of care).

NHS England data showed that from September 2020 to August 2021 the average length of stay for medical elective patients at the hospital was 5.0 days, which is lower than England average of 6.4 days. For medical non-elective patients, the average length of stay was 7.1 days, which is higher than England average of 5.8 days during this period.

The average length of stay for elective patients in clinical haematology and gastroenterology was higher than the England average and for elective patients in cardiology this was lower than the England average. For non-elective patients, the average length of stay for patients in general medicine, respiratory medicine and cardiology was higher than the England average during this period.

Delayed Discharges

NHS England data for March 2021 to April 2022 showed the overall proportion of delayed discharges across the hospital had steadily increased,, indicating a worsening trend.

From January 2022 to April 2022, delayed discharges across the hospital had been worse than integrated care system (ICS), regional and national averages for overall delayed discharges.

The trust reported that on 24 April 2022, 81 patients had not met the criteria to reside; 18 of these patients were planned for discharge the following day, 33 of these patients had been delayed over 21 days (of which five were planned for discharge the following day).

Managers monitored the number of patients whose discharge was delayed. The trust reported there had been no delayed discharges for hospital attributable reasons in March 2022. The main reasons for delayed discharges were due to community reasons.

Managers and staff started planning each patient's discharge as early as possible. We saw there was daily involvement from discharge coordinators, consultants and pharmacy staff to facilitate patient discharges. However, we found that ward staff did not routinely involve social workers in the discharge process until patients had been confirmed as medically fit for discharge. This meant there could be a delay in patients requiring transfer of care to the community.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The services had an integrated discharge hub that included a multidisciplinary team (including social workers) to improve delayed discharges. The services had a number of action plans in place to improve discharge processes and progress was monitored as part of fortnightly discharge group meetings.

There was integrated care system-wide action plan to reduce the number of patients who do not meet the criteria to reside, and to decrease the number of patients discharged after 5pm. The trust had an improvement plan trajectory to reduce the percentage of patients discharged before 5pm from 49% to 40 by the end of June 2022. The plan also included an improvement trajectory to reduce the number of beds occupied by patients with no criteria to reside and not discharged from 10% to 7% by the end of June 2022.

The transfer of care hub included the home first model for discharging patients. The home first model aimed to discharge patients on the same day or within 24 hours of being declared medically fir for discharge.

Records showed referrals to the transfer of care hub had continually increased each month from September 2021 to March 2022. The transfer hub team's triage time showed an improving trend from 2.1 days in January 2022 to 1.75 days in February 2022 and 0.9 days in March 2022.

Outliers

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. The average number of daily medical outliers ranged between 42 and 63 patients during November 2021 to April 2022.

Staff told us patients in non-specialty areas were assessed and deemed suitable to receive care in those wards. The medical consultants and doctors had a daily list of patients that were placed in other wards so these patients could be reviewed daily. Patient records showed that patients were reviewed by doctors from the relevant specialty on a regular basis.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Medical care (including older people's care)

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. This included information about the patient relations team. The patients we spoke with were aware of the process for raising their concerns with the staff.

Managers investigated complaints and identified themes. The ward managers and clinical leads were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team, who notified individual managers when complaints were overdue.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that information about complaints was discussed during daily 'safety huddles' and at routine meetings to aid future learning. We saw evidence of this in the meeting minutes we looked at.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The trust complaints policy stated that complaints would be acknowledged within three working days and responded to within 25 working days for routine formal complaints and within 40 working days for complex complaints.

From April 2021 to March 2022 there were 56 complaints about the medical wards in the IMPF division and six complaints about the medical wards in the tertiary services division. Records showed 84% of complaints relating to the medical care services were responded to within the timescales specified in the trust complaints policy. The most frequent reasons for complaints were discharge issues, communication and staff attitude.

Is the service well-led?

Requires Improvement ↑

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Whilst leaders understood the priorities and issues the service faced, key risks and issues affecting the service were not always managed effectively. Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

We identified concerns around leadership during our previous inspection in October 2021. At that inspection, we reported that leaders had the skills and abilities to run the service. However, they did not always understand or manage the priorities and issues the service faced.

We found the divisional leadership structures were more embedded since the previous inspection. The matrons, clinical heads of department and divisional triumvirate leads fully understood the challenges facing the service and had implemented some improvement measures. However, the actions taken to address issues or reduce their impact did not always result in effective and timely improvements across the services.

The medicine care services at the hospital were provided by two separate divisions; the integrated medicine and patient flow (IMPF) division and the tertiary services division.

Medical care (including older people's care)

The IMPF division and tertiary services division was led by a triumvirate leadership team made up of the divisional director, divisional director of operations and a divisional director of nursing. The triumvirate leads were supported by senior staff with associate and deputy director roles across the triumvirate disciplines.

The IMPF divisional director had been in post for approximately nine months whereas the divisional director of operations had been in post for two years. The leadership team for tertiary services had been in place since the formation of the tertiary services division in April 2021. They told us the leadership teams had only been in place for a few months at the time of our previous inspection in October 2021 but they had strengthened divisional governance meetings and reporting processes since the previous inspection.

Each directorate was led by a triumvirate team consisting of the heads of department (clinical leads), matrons and directorate managers who were also supported by service and support managers. The day to day running of the medical wards was overseen by ward managers.

Leaders at ward, directorate and divisional level had good understanding and oversight of the key risks relating to their services. The majority of staff spoke positively about the leadership and organisation structure. Staff told us they understood the reporting structures clearly and described their line managers and senior divisional managers as approachable, visible and who provided good support.

Key roles were supported by deputies or associate roles to support succession planning. We also found examples of recruitment planning and staff development for medical staff in the ward areas to support succession planning for consultants that were due to retire.

Vision and Strategy

Whilst the service had a vision for what it wanted to achieve; this had not yet been developed into documented local strategies. This meant staff did not fully understand or know how to apply the strategic objectives and monitor progress.

The trust's brand statement was 'together we care'. This was supported by four corporate values; people centred, positive, compassion and excellence.

The trust had developed its overall strategy for the next five years and this was scheduled for launch in June 2022.

The draft trust strategy included strategic objectives for the integrated medicine and patient flow division (IMPF) and the tertiary services division. The IMPF division objectives included launching the hyper-acute stroke unit (HASU), developing the frailty model, improving patient length of stay and ward accreditation and triumvirate leadership development. The tertiary services objectives included repatriation of services, clinical pathway redesign, to become the lead provider of cardiac services, improve ward accreditation and triumvirate leadership development.

The IMPF and tertiary services were in the process of developing divisional strategies, based on the overall trust strategy, vision and values. The divisional leaders were able to verbally explain the key priorities and objectives for their services over the next 12 months. There was an implementation plan that included timescales for the development and full launch of the new divisional strategies during June 2022. The plan included details of involvement and engagement with staff, patients and stakeholders in the development of the divisional strategies.

We saw some information around the trust vision and values displayed in the medical wards. However, ward staff were unable to comment on the strategy and objectives as these were being drafted.

Medical care (including older people's care)

Culture

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

The staff we spoke with were highly motivated, patient-focussed and spoke positively about working in the medical care services. They told us there was a friendly and open culture and that matrons and clinical leads were visible and approachable.

The medical and nursing staff we spoke with told us they received regular feedback to aid future learning and that they were supported with their training needs by their line managers. Junior doctors and nurses told us they received good training and learning opportunities.

Most staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared. The majority of staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed.

Governance

Leaders did not always operate effective governance processes. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

At the previous inspection in October 2021, we reported we were not assured that leaders operated effective governance processes throughout the service.

During this inspection we found some improvements had been made and key risks and performance issues were routinely reported and discussed at departmental and divisional governance meetings. We found the governance and reporting processes enabled divisional leaders to understand the key risks and challenges to the services and implement improvement actions. However, the actions taken to address key issues or reduce their impact did not always result in effective and timely improvements in the management of risks, issues and performance across the services.

Each medical ward / specialty area had routine monthly governance meetings to discuss governance, risk and performance. The IMPF division and tertiary services division held divisional quality assurance meetings and divisional clinical effectiveness meetings every six weeks and reported to the divisional board meetings, which were also held every six weeks.

We reviewed the minutes of ward governance meetings and divisional quality assurance, clinical effectiveness and board meetings and these included key discussions around current risks, incidents, clinical governance and performance issues in relation to each medical speciality area.

The divisional meetings received information and data relating to key risks, performance and governance issues, which meant divisional leaders had oversight of current concerns. The departmental and divisional meetings had actions plans that were reviewed and updated at the subsequent meetings.

Medical care (including older people's care)

The collaborative organisation accreditation systems for teams (COAST) ward accreditation programme was in place since January 2021 to assess the quality of care delivery in the medical wards. The assessment was carried out by a multidisciplinary team and covered key criteria based on the Care Quality Commission's inspection standards and involved speaking with staff, patients and review of approximately four to ten patient records. Wards that had been assessed were given an overall rating of gold, silver and bronze.

The most recent accreditation results for 23 medical wards showed nine wards had achieved a 'gold' rating, 10 wards had achieved a 'silver' rating and three wards had achieved a 'bronze' rating. The results also showed five of the 23 wards had improved, five wards scored worse and 12 wards had stayed the same since the previous accreditation assessment.

Findings from the accreditation assessments were reviewed by the ward managers and matrons and shared with ward staff to aid learning and improve compliance. Each medical ward had an action plan in place to improve compliance and this was monitored as part of routine meetings.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues or identify effective and timely actions to reduce their impact.

We identified concerns around risk management processes during our previous inspection in October 2021. At that inspection, we reported that risks were not escalated appropriately through clear structures and processes. The divisional risk registers had high numbers of risks, with many that had been open a long time. Risks were not escalated appropriately through clear structures and processes.

During this inspection, we found some improvements had been made in relation to the management of risk registers but further improvement was still required in relation to escalating new and emerging risks.

Staff used an electronic risk register system to record and manage key risks. The IMPF division and tertiary services division maintained divisional risk registers to document key risks relating to the overall divisional risks and also incorporated the individual departmental / ward risks.

The tertiary services reported the divisional risk register had been updated and the number of listed risks had reduced from 279 risks in June 2021 to 71 risks in April 2022. The IMPF Quality assurance committee meeting minutes (March 2022) reported the division had 176 items on the divisional risk register.

Staff were supported by governance leads within each division to review open risks and identify mitigations / controls to reduce or eliminate risks. The risk registers showed key risks were reviewed and updated and this was monitored at routine divisional quality assurance and divisional board meetings.

The individual risks were reviewed and assessed to identify actions for improvement and governance leads reported on performance in relation to progress against open risk actions. Meeting minutes over the past six months confirmed this.

The IMPF and tertiary services divisional risk registers for April 2022 included specific risks relating to patients transferred as part of full capacity (surge) protocol, staffing shortfalls, delayed discharges and referral to treatment risks. However, the risk registers did not refer to significant risks and concerns identified during this inspection and the previous inspection, such as shortfalls around rapid tranquilisation processes. The risk registers did not include specific risks relating to sepsis management.

Medical care (including older people's care)

We identified concerns around staffing, mandatory training compliance, management of incidents and clinical prioritisation and performance against referral to treatment waiting time standards during our previous inspection in October 2021. We found some improvements had been made in relation to incident management processes. However, we identified shortfalls in nurse and medical staffing in some of the wards we inspected during this inspection.

Divisional meeting minutes showed performance around training compliance was routinely discussed and leaders were aware of shortfalls in training (such as medical staff resuscitation training). However, there had been no significant improvement in mandatory training compliance since our previous inspection.

The medical care service reported a number of improvement measures and initiatives being undertaken to improve patient discharge processes and referral to treatment standards. However, recent data showed there had been a worsening trend in performance, indicating the improvement actions undertaken had not been effective in addressing key performance issues.

We had raised concerns around rapid tranquilisation processes during our previous inspection and found further concerns during this inspection, which demonstrated a lack of learning and improvement.

We saw that routine audit and monitoring of key processes took place to monitor performance against objectives and this was monitored at routine divisional meetings and cascaded to staff through team meetings, safety huddles and newsletters.

The audit records we looked at showed there had been improved staff compliance in processes such as infection prevention and control and mental capacity and DoLS processes. However, audit findings for medicines management and nutrition and hydration processes highlighted poor staff compliance. Action plans were in place to improve audit compliance but these were not always effective.

We identified significant concerns around the management of patients with suspected or confirmed sepsis. The trust's internal Aqua sepsis audit data showed poor compliance with a worsening trend over time, however there was no effective plan in place to improve performance.

The sentinel stroke national audit programme (SSNAP) clinical audit data showed compliance in the stroke unit had deteriorated since the previous audit.

The IMPF division reported in April 2022 that nine out of 97 divisional policies had expired and were currently in the process of update or review. Seven of these policies had expired since November 2021 and had not been updated and ratified at the time of our inspection, which demonstrated a lack of pace in addressing routine governance issues.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. However, integrated clinical dashboards were not used consistently across the services.

The divisional and directorate level meeting minutes included information and data around governance, performance and risk used for analysis and oversight during these meetings. This was mainly presented through update reports and briefings.

The tertiary services division had an integrated performance dashboard which provided information around key performance indicators for the current and previous month. The dashboard for April 2022 was also displayed on notice boards in a number of the tertiary service medical wards. The integrated medicine and patient flow (IMPF) division reported they had not yet developed a similar integrated clinical dashboard.

Staff completed information governance training as part of their mandatory training and the internal target was for 95% of staff to have completed this training. Records showed that as of April 2022, 88% of medical staff and 93% of nursing staff in the IMPF division had completed information governance training.

The trust used paper-based patient records so patient information was easily accessible for staff. Staff used pre-printed care pathway booklets, such as nursing assessments, and these were version-controlled and readily available. Staff files and other records (such as audit records, staff rotas and complaint files) were kept securely on each ward.

The divisional triumvirate leadership for the IMPF division and tertiary services division told us there had not been any data breach incidents that were reportable to the Information Commissioner's Office (ICO) in the past 12 months.

Computers were available across the wards areas and staff access was password protected. The staff we spoke did not identify any concerns relating to accessing information technology (IT) systems or any connectivity issues.

Staff could access policies, procedures and clinical guidelines through the hospital's intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Engagement

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

Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the areas we inspected. The trust also engaged with staff through team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.

The NHS Staff survey 2021 results showed the trust performed better than national averages for eight of the nine overall indicators. This included compassion and inclusivity, being heard, engagement, recognition and reward, flexible and team working, morale and safety culture. The trust scored slightly worse than national average for one indicator; 'we are always learning (trust score 5 compared with average of 5.2).

The divisional action plan for the NHS staff survey for last year (2020) showed most improvement actions had been completed. The divisional triumvirate leads for the IMPF division and the tertiary services division told us the findings from the NHS staff survey 2021 had been reviewed and draft action plans were currently being developed to cascade across the medical care teams.

Staff could access trust-wide support through HR and occupational health services for emotional and well-being support. The medical and nursing staff participated in specific events and training days that included engagement, training and discussions around improvements to clinical processes. Senior managers told us they carried out regular walk rounds to engage with staff across the medical wards.

Medical care (including older people's care)

Staff across the medical care services told us they routinely engaged with patients to gain feedback from them. This was done informally and formally through participation in the NHS Friends and Family. Feedback from the NHS Friends and family survey was mostly positive across the medical wards.

Public engagement had been impacted due to the Covid-19 pandemic; however we saw evidence that patient and public engagement took place through routine influence meetings, patient carer group meetings and through general information on the trust's website.

Learning, continuous improvement and innovation

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

The culture across the services was based on quality improvement (QI). There were a number of quality improvement projects and work streams in place across the medical care services, such as preventing non-ventilator hospital acquired pneumonia (respiratory wards), Improving the compliance of VTE risk assessments (ward 12) and Improving documentation and clerking compliance on the acute medical unit (AMU).

The clinical quality academy had a number of improvement projects relating to medical care pathways, including for standardised ward processes, heart failure pathways and the emergency department to AMU Pathway.

The QI project on ward 5 (respiratory) involved the introduction of the 'COUGH' bundle for preventing hospital acquired pneumonia (HAP). The incidence of HAP improved from 16.7% to 2.4% following the introduction of the care bundle.

Staff across the services were involved in research, innovation and clinical trials to improve patient care and treatment and routinely attended trust-wide research, development and innovation committee meetings.

Outstanding practice

We did not identify any areas of outstanding practice as part of this inspection.

Areas for improvement

MUSTS

Medical care

- The service must implement an effective system to identify, escalate and manage patients who may present with sepsis. (Regulation 12 (1)(2)).
- The service must implement an effective system to ensure that patients requiring rapid tranquilisation are assessed and monitored appropriately and are safe from harm. (Regulation 12 (1)(2)).
- The service must take actions to ensure the implementation of effective systems and processes to safely prescribe, administer, record and store medicines. (Regulation 12 (2)(7)).

Medical care (including older people's care)

- The service must take actions to improve performance around referral to treatment wait time standards, delayed discharges and patient bed moves. (Regulation 17 (1)(2)).
- The service must take actions to improve patient records to ensure they are clear and up-to-date. (Regulation 17 (2)(3)).
- The service must ensure appropriate actions are taken to implement effective governance and risk management processes to enable timely improvements in the management of issues and performance. (Regulation 17 (1)).
- The service must ensure the service has enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. (Regulation 18 (1)).
- The service must improve staff compliance in mandatory training, including life support and safeguarding training. (Regulation 18 (2)(1)).
- The trust must ensure that there is an effective system of annual appraisal in place, to ensure that all staff are supported to fulfil their roles. (Regulations 18 (2)(1)).
- The service must take appropriate actions to ensure staff receive competency-based training relevant to their role. (Regulation 18 (2)(1)).

SHOULDS

Medical care

- The service should ensure risk assessments for patients admitted through the full capacity protocol are documented. (Regulation 12 (1)).
- The service should ensure patients admitted through the full capacity protocol have their privacy and dignity maintained and receive clear information whilst awaiting an inpatient bed. (Regulation 10 (1)).
- The service should take actions to improve clinical audit outcomes relating to stroke pathways. (Regulation 12 (1)).
- The service should continue to develop local strategies and cascade to staff across the medical care services. (Regulation 17 (1)).
- The service should consider developing integrated clinical dashboards to improve information management. (Regulation 17 (1)).
- The service should take actions to improve weekend medical cover in the stroke services. (Regulation 18 (1)).

Urgent and emergency services

Inspected but not rated

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC (Care Quality Commission) is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care.

Blackpool Victoria Hospital provides a range of acute hospital services in the locality of Blackpool and the Fylde Coast, England.

We carried out an unannounced focused inspection of Blackpool Victoria Hospital urgent and emergency care services (also known as accident and emergency or A&E (Accident & Emergency)) between the dates of 19 and 20 April 2022.

As this was a focused inspection, we only inspected parts of our five key questions. This was part of a CQC national programme for urgent and emergency care system inspections. This inspection was partly undertaken due to the concerns raised over how the organisation was responding to patient need and risk in the department and to determine how the flow of patients who started their care and treatment in the emergency department was managed in times of high pressure.

The emergency department was previously rated as inadequate overall. For this inspection we considered information and data on performance for the emergency department but did not re-rate the service.

- The service did not always provide mandatory training in key skills, including the highest life support training, and safeguarding. The service did not always control infection risk well and ensure control measures were in place to protect people from infection. The design, maintenance and use of facilities and premises did not always keep people safe. Staff did not always complete risk assessments and risks were not always removed or minimised, including deterioration. The service did not employ enough nursing and support staff and did not always have enough medical staff. The service did not use systems and processes to safely prescribe, administer, record and store medicines. Leaders did not always robustly identify lessons to improve patient safety. Staff did not always recognise and report incidents and near misses appropriately. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.
- Managers did not always check to make sure staff provided care and treatment based on national guidance and evidence-based practice. They did not always use the findings of audits to improve outcomes for patients. The service did not always demonstrate staff were competent for their roles. Managers did not always undertake staff appraisals on a yearly basis.
- Staff and leaders did not consistently maintain patient's privacy and dignity.
- People could not always access the service when they needed it and did not always receive the right care promptly; waiting times for medical assessment, treatment and admission and discharge were prolonged.
- Staff told us they felt extremely stressed and the constant demand impacted the care they would like to provide. They did not always have the resources, support and space to manage the priorities and risks the service faced. Leaders did not always develop effective plans to learn from performance and did not always identify actions to reduce the impact of incidents in a timely manner.

However:

Urgent and emergency services

- Leaders were aware of poor compliance levels and had developed improvement plans. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The service was beginning to embed a better process for managing patient safety incidents. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff monitored the effectiveness of care and treatment.
- Staff treated patients with compassion and kindness.
- Leaders had the skills and abilities to run the service and were visible and approachable. Staff were focused on the needs of patients receiving care. The service was beginning to operate effective governance processes. Leaders and teams used systems to manage performance. Local leaders identified and escalated relevant risks and issues.

Is the service safe?

Inspected but not rated

Mandatory Training

The service did not always provide mandatory training in key skills. Staff did not always receive life support training at the highest levels. However, leaders were aware of compliance levels and had developed improvement plans.

The service did not always provide mandatory training in key skills. Staff did not always receive life support training at the highest levels. However, leaders were aware of compliance levels and had developed improvement plans.

Staff did not always receive and keep up to date with their mandatory training. We reviewed the trust's mandatory training completion rates. The service aligned itself to the skills for health; core skills training framework's (CSFT) recommended subjects, including safeguarding adult's and children's. However, leaders did not always ensure compliance rates met the trust's target of 95%.

In April 2022, 10 of the 11 mandatory training compliance rates for medical staff were below the trust's target. These included all the subjects except for the prevent radicalisation from the CSFT. For nursing staff, eight out of the 11 mandatory training compliance rates were below the trust's target.

Staff did not always receive and keep up to date with life support training. The service provided compliance rates for adult basic life support (BLS) level two, which included defibrillator training. From September 2021 to February 2022, average compliance rates showed 90% of nursing staff and 54% of medical staff were trained yearly. Compliance rates for children's annual BLS level two were from September 2021 to February 2022, average compliance rates showed 85% of nursing staff and 35% of medical staff were trained yearly.

Since our last inspection, the service had reduced the compliance target to 90% for BLS. We requested but did not receive the evidence to support that the provider ensured staff were trained to the highest level of life support.

Managers monitored mandatory training and were aware that they had low mandatory training compliance levels. Leaders had created an action plan to improve training adherence to meet trust targets. Improvement action plans stated the service allocated two hours in the medical staffing rota for each member of staff to complete mandatory training.

Urgent and emergency services

Safeguarding

Staff did not always have training on how to recognise and report abuse but staff we spoke with knew how to action concerns. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff did not always receive training specific for their role on how to recognise and report abuse. In April 2022, we were given compliance rates for children's level three safeguarding which showed 87% of nursing staff and 44% of medical staff had up to date training. Compliance rates for adult's level three safeguarding showed 96% of nursing staff and 53% of medical staff had up to date training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could explain the safeguarding process and provided examples of recent referrals made. We were told that staff did not always receive feedback on referrals but received confirmation the referral had been made. Weekly safeguarding meetings took place with senior leaders to discuss any safeguarding concerns raised, both paediatric and adult concerns were included.

Staff followed safe procedures for children visiting the ward. The children's emergency department and separate waiting room for children were in a secure environment. Children were booked in at reception and directed to the children's waiting room, which was secure with an intercom system to control entry.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

The department had suitable furnishings which were well-maintained. The service did not always perform well for cleanliness. The service's most recent infection prevention and control audit completed from January to March 2022, showed compliance rates of 88%. During inspection we observed that some areas of the service were cluttered and dusty.

Staff followed infection control principles including the use of personal protective equipment (PPE). During inspection, we saw that staff were wearing appropriate PPE when required, all staff were wearing facemasks.

However, the service did not always ensure that patients with infections were isolated. We observed that the service had patients with COVID-].9 infections in the rapid access triage (RAT) area, in a cubicle which did not have doors. However, the service had a separate COVID-].9 infection waiting area in place.

We observed that social distancing screens were in place. However, the department was overcrowded so social distancing was difficult to maintain.

The infection prevention and control (IPC) training was included in the trust's mandatory training requirements. Since the last inspection, the service had reduced the compliance target to 90% for IPC training. However, managers did not always ensure staff had IPC training. The service provided infection prevention control level two training results varied in staff groups from 62% to 96%. Junior medical, consultant medical and unregistered nursing staff were below the trust compliance target.

The service contained ample hand washing facilities including sinks. We observed that staff were following guidance on hand hygiene. From January to March 2022, the service had hand hygiene audit compliance of 95%.

Urgent and emergency services

Environment and equipment

The design, maintenance and use of facilities and premises did not always keep people safe. Staff did not always manage clinical waste well.

The service did not always have suitable facilities to meet the needs of patients' and their families.

The service had three entrances into the department, one for patients walking-in, one for ambulances and one into the isolation area.

Walk-in patients were booked in at a reception desk in the main reception. The waiting room was in the main reception area and there was a separate waiting area for patients with confirmed COVID-19 infections. Since our last inspection, the service had started to use the waiting are to care and provide treatment for patient. This was an unsuitable environment because it was overcrowded and patients in the waiting room received care and treatment including observations, intravenous medications and intravenous fluid infusions. We observed patients' intravenous fluids hanging from leaflet holders, instead of drip stands.

During our inspection, the department was overcrowded due to high levels of demand and lack of flow. Staff told us they were concerned about the ability to maintain privacy and dignity effectively while the department was overcrowded. Since our last inspection, the service had identified 19 escalation spaces, or corridor spaces spread throughout the department. These were part of the trust's escalation planning and were identified for use when the department was experiencing high demand.

The service has an isolation area consisting of one triage room and four treatment cubicles. Isolation room cubicles were reserved for patients who were infectious or require aerosol generating procedures (AGP's), such as intubation. Each of the resuscitation and isolation room spaces had a defibrillator and continuous monitoring. However, the isolation rooms spaces did not include telemetry facilities. This meant that staff were unable to monitor the patients' physiological parameters from a distance.

Patients could not always reach call bells. Patients within escalation spaces did not have access to nursing call bells to request assistance when required. This meant that patients could not call for help when required, which could lead to harm.

Staff did not always carry out daily safety checks of specialist equipment. From October 2021 to March 2022, daily and weekly safety checks of the resuscitation trolleys were missed, on average, 8% of days per month. Fridge temperatures were not always checked daily, we saw that four of the first 19 days in April 2022 were not recorded.

Staff disposed of clinical waste safely. Sharps bins were available within the department, but we did not always see temporary closure devices in use when sharps bins were unattended.

Patients told us that given the extended lengths of stay they experienced in the department, there was insufficient washing facilities or showers. Patients who had waited overnight in the waiting room and the corridor's told us they had not been offered washing facilities.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient swiftly. Risks were not always removed or minimised. Staff did not always identify and act quickly upon patients at risk of deterioration.

Urgent and emergency services

Managers monitored waiting times but did not always make sure patients could access emergency services when needed. The service did not meet the national standard of triage to be completed within 15 minutes of arrival. During inspection, we saw that triage times for patients who walked in the emergency department varied from 15 minutes to three hours and 15 minutes. The department had a standard operating procedure for the triage nurse within the emergency department, dated March 2022. A modified Manchester triage system was used at streaming.

The service was in the process of undertaking a streaming project that began at the end of March 2022. The aim was to improve the results of triage for patients who walk-in and ensure that appropriate streaming was being completed. It included a system of PDSA (Plan/Do/Study/Act) cycles to review the process and make changes. The project noted that without enough staffing to stream patients then the process was not achievable.

During our inspection, we saw that the service had made improvements in providing an unregistered nurse to undertake urgent echocardiograms and blood tests if required after streaming. We observed non-clinical reception staff indicating that a patient complaining of chest pain had booked into the department. The patient was immediately brought into the assessment room for an echocardiogram, tracing of the heart, and assessed. The national guidance is that echocardiograms should be obtained within 15 mins of presentation with chest pain. The service monitored the compliance through the consistency in care audit, from 04 April to 13 April 2022, 84% of echocardiograms were taken within 15 minutes of chest pain presentation. This was an improvement since the last inspection.

In the six-week period from 28 March 2022 to 02 May 2022, on average 558 patients arrived by ambulance per week. Data showed on average that ambulances waited in 25% of cases between one and three hours, and 3% of ambulances waited over three hours at hospital with patients. During the six-week period, on average the longest handover was six hours and three minutes. Therefore, this was causing delays for ambulance crews to attend patients waiting in the community.

On 19 April 2022, we saw eight patients waiting in ambulances for access to the emergency department for care and treatment. During our inspection, patients on ambulances were waiting up to one hour and 26 minutes for initial triage. We were told that delays were due to capacity issues. This was similar to the previous inspection. This meant that there could be delays in recognising unwell patients and starting urgent treatments in a timely manner. However, the service had significant capacity concerns but leaders had limited opportunities to improve access and flow.

The number of patients leaving the service before being seen for treatment was higher than the national average. In March 2022, the percentage of patients who left without being seen was 12%. From January 2021 to December 2021, most of the monthly percentages of patients leaving without being seen were twice (worse than) the national percentage.

Patients did not always receive treatment within agreed timeframes and national targets. The Royal College of Emergency Medicine recommend that the time patients should wait from the time of arrival to receiving treatment should be no more than one hour. The service did not always meet this standard from January 2021 to January 2022. During our inspection, we saw significant delays for medical staff to see patients ranging from 3 hours and 35 minutes to 10 hours and three minutes. Patients were waiting prolonged time frames before having treatments started, which could lead to patient harm.

Urgent and emergency services

During our inspection on 19 and 20 April 2022, we looked at eight patient's medical records in the emergency department. We found eight patients with signs and symptoms of sepsis who were not always treated in a timely manner following National Institute for Health and Care Excellence (NICE) guidance. We saw that the trust's sepsis pathway checklist was incomplete in all eight medical records. Delays in recognition and early treatment of sepsis could lead to harm.

Therefore, on 22 April 2022, we imposed urgent conditions under Section 31 of the Health and Social Care Act 2008. The service did not have an effective process in place for identifying and managing patient risk for service users who presented with suspected or confirmed sepsis. The provider was failing to ensure safe and timely identification, management and documenting of sepsis, which meant there was a significant risk that service users could be exposed to a serious risk to life, health or wellbeing.

Staff did not always identify and quickly act upon patients with signs and symptoms of cauda equina. Cauda equina syndrome is a rare disorder where there is pressure on the nerves at the bottom of the spinal cord. It requires urgent investigation to prevent the nerves from becoming permanently damaged. We were told that some patients with cauda equina symptoms were discharged home to return for MRI scans the following day. During inspection, we saw that there was no follow up system to identify and ensure that discharged patients returned for their MRI scans. In the last year, we saw four incidents related to cauda equina delays. The service did not have mechanisms in place to ensure that patients returned and were referred for treatment, when required, which could lead to harm.

Staff did not always complete risk assessments for each patient on arrival, but the service used a recognised tool. The service had the recognised tools for Waterlow scores and falls assessments embedded within the electronic system. On 20 April 2022, we observed a frail elderly patient who was being transferred from an emergency department trolley to a hospital bed after 20 hours and 45 minutes, the patient had not had a Waterlow assessment completed. During inspection, we saw results of the consistency of care audit between the 02 March 2022 to 03 May 2022. The audit showed that on average 56% of the time skin was inspected. Therefore, patients were not always risk assessed, in a timely manner, and actions were not always taken to protect patients from harm.

Staff knew about specific risk issues but did not always manage them safely. On the 19 April 2022, we observed a patient in the isolation area, behind a closed door, who was trapped in the railings of the trolley and was about to fall out of the bed. We escalated this immediately during the inspection due to the safety risk. This patient was identified as a high risk of falls but it was not clear within the records if any mitigations had been put in place. Patients who may be at risk of falls were not always observed and risk assessed appropriately.

Staff used a nationally recognised tool to record observations but did not always identify and escalate them appropriately. For adult patients, staff used the national early warning score version two (NEWS2) to record patient observations and identify deterioration. Leaders monitored NEWS2 compliance through 10 randomly selected medical records daily. This was named the consistency in care audit. Data provided after our inspection, indicated that on average from 02 March 2022 to 03 May 2022, 74% of patients had observations recorded in line with NEWS2 guidance. We did not see that leaders used the audit to improve care and treatment as there was no subsequent action plan.

We saw two patient records with deteriorating observations who did not have documented evidence of escalation and actions taken. The COAST assessment completed in March 2022 recognised that patients with raised NEWS scores, indicating deterioration, did not have observations repeated as per policy. This meant that all patients with a deteriorating medical condition may not always be recognised and escalated appropriately for timely care and treatment.

Urgent and emergency services

Nurse staffing

The service did not employ enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The emergency department used a high number of internal bank and agency staff. Managers regularly reviewed staffing levels and skill mix but could not always ensure staffing requirements were available.

The number of nurses and healthcare assistants did not always match the planned numbers. The service provided the actual staffing from 17 January 2022 to 24 March 2022. The data showed that actual staffing matched the increased, agreed, establishment requirements for registered nursing staff in 60% of the dates provided. Actual staffing matched establishments in 2% of the dates provided for unregistered nursing staff. This meant that the service was unable to meet the increased staffing establishment required to keep patients safe from harm.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, the service did not employ enough nursing and support staff to keep patients safe.

Senior leaders told us during 2019 the emergency department reviewed their nurse staffing establishment to align it to the Royal College of Nursing Workforce Standards. This document was named the budgeted establishment. Since 2019, the service agreed to increase staffing numbers by 25 registered and 11 unregistered nursing staff per day, over the varying shifts. This increased staffing establishment included three registered nurses to care for patients waiting on the corridor and waiting room. The trust reported following the inspection that the finance and performance committee had approved a business case in May 2022 that set out the future staffing requirements for the emergency department. The trust reported the emergency department was actively recruiting to the agreed in line with Royal College of Nursing (RCN) workforce standards.

The service required internal bank and agency nursing staff to cover the increased establishment. We reviewed agency staffing data from October 2021 to March 2022, the emergency department required on average 362 registered agency nurse shifts per month. The fill rates of bank and agency nurses were on average 75%, over the six months. We requested but did not receive evidence of the unregistered internal bank and agency nursing figures broken down by department. There was a high reliance on bank and agency nurses in the emergency department which could lead to a lack of assurance that all nurse staffing requirements were filled appropriately.

The service had recognised the nursing establishment had a shortfall and that it caused an inconsistent approach to safe nursing staffing levels. However, local leaders had completed a review of establishments required but had not acted in a timely manner to gain approval and funding to create established employed staff.

Within the children's emergency department, the service had two trained registered nursing staff on every shift as recommended by the Royal College of Paediatrics and Child Health. The service provided nursing staffing rotas from 03 January 2022 to 24 April 2022, on average 92% of shifts had two registered children's nurses working. The service had 94% of shifts filled with unregistered nursing staff within the department.

Staff did not always share key information to keep patients safe when handing over their care to others. Staff told us they felt concerned about the continuity of care. They said they did not always receive enough key information to keep patients safe. The nurse-in-charge handover occurred in a private room. The handover included the number of patients in the department overall and in each area. In addition, the number of patients waiting to be seen by a doctor or waiting for a bed allocation was discussed. On observation, not all patients and management plans were shared. On the 19 April

2022, out of the 97 patients in the department, 14 patients were named and discussed. These included some of the patients who were unwell in the varying areas of the department, and those in the isolation rooms and emergency room. This showed that in times of pressure information was shared regarding the unwell patients, but there was no detail regarding the other majors patients waiting for care and treatment.

We observed that the service used laminated sheets stuck to the desks in each area to monitor patient care. It included next observations due, medications given and SAS tool (which includes skin inspections, turning, continence and nutrition). This was an example of effective practice to share information with other staff and ensure patients had care and treatments in a timely manner.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels but did not always have enough staff to match the planned requirements.

The service did not always have enough medical staff to keep patients safe. The service provided the rotas for the last three months. From 07 February 2022 to 08 May 2022, there were noticeable gaps in the rotas for senior decision makers over weekends. However, the service had recognised this as a risk on their divisional risk register and had control measures in place.

The service had high vacancy rates for senior medical staff, specifically consultants in the emergency department. The service had 5.25 out of 18 full time equivalent consultant vacancies but 1.2 out of 28 full time equivalent vacancies for registrars. We were told the service had recruitment plans in place to increase the medical staffing. Leaders had over recruited associate specialist doctors by nine full time equivalents to mitigate some of the risk.

The service did not always have a good skill mix of medical staff on each shift and reviewed this regularly. From 07 February 2022 to 08 May 2022, the medical staffing rota had noticeable and consistent gaps in core trainee doctors, foundation year one and advanced nurse practitioners during night shifts. Although, managers could access locums when they needed additional medical staff. It was not clear within the rotas if shortages were filled with temporary staff or how the service mitigated the shortages. At the 8am morning handover on 20 April 2022, we saw that the wait to be seen by a doctor was 10 hours and 3 minutes in majors, this improved by 1pm when the wait to be seen was two hours and 45 minutes. The rotas did not always demonstrate that there were enough medical staff to see patients overnight in a timely manner.

The service always had a consultant either on duty or on call during evenings and weekends and at least one consultant allocated to work each shift. This aligned to the Royal College of Emergency Medicine (RCEM) consultant workforce recommendations.

The service did not have job plans for all consultants. On 26 April 2022, for both urgent and emergency care and medicine 14 out of the 68 consultants had job plans agreed. However, since our last inspection the trust recently moved to prospective job planning rather than retrospective. This meant that the provider had started a system to consistently agree and track the progress of job planning for all senior doctors within the hospital. Leaders held weekly job planning meetings to track positions and progress and quarterly job planning panels to ensure consistency. The process had been agreed to become a permanent fixture, as of May 2022, but the progress to agree all job plans would take time to

complete. This was an improvement from the last inspection. The service had recognised that job planning was a risk and it was reflected in the divisional risk register. In response, the trust had developed a medical workforce committee to monitor and ensure that the medical workforce trust wide was being managed effectively which included the job planning for all consultants.

Staff did not always share key information to keep patients safe when handing over their care to others. We observed the morning handover between day and night medical staff. The handovers did not include the detail of management plans just if the patient had a plan in place or not and not all patients were discussed. On the 20 April 2022, the medical handover consisted of discussion of five complex patients of the 89 patients in the department. However, we did not see consultants offer to review and assess complex patients. Medical staff had one formal handover for all staff once a day in the morning. Other, handovers occurred informally with individual staff.

The emergency department did not have a paediatric emergency medical (PEM) consultant employed. The divisional risk register did not specify the gap in PEM consultants and did not specify control measures in place. The service told us that a clinical lead with a paediatric interest had been assigned to support the role. We were told that a paediatric advanced nurse practitioner was allocated to work in the paediatric department, but sometimes there were delays to care and treatment if a medical doctor was busy elsewhere. Patients did not always have timely access to a PEM consultant, which could lead to harm.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. But did not always ensure critical medicine were given in a timely manner.

Staff followed systems and processes when safely prescribing, administering, recording, and storing medicines. Patients receiving medicines in the department were started on a paper prescription chart, which would transfer with the patient if they were admitted to wards. Having one prescription chart made it clear when a medication had been given to prevent it from being given again. The trust had approved an electronic prescribing system, which was to be implemented across the trust.

Following the previous inspection, a business case had been approved to expand the emergency department pharmacy service, increasing the number of pharmacists, pharmacy technicians and assistants. The team were very much embedded within the department and nursing staff said they continued to make a big difference.

Medical, pharmacy and nursing staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. We were told that there were no longer 500 outstanding discharge letters to be sent to patients' doctors after discharge as they had now been fully completed. This was an improvement from the previous inspection.

However, we still continued to find some critical medicines including antibiotics had not been administered in a timely manner. Antibiotic audits we reviewed looked at compliance against the antibiotic formulary but did not look at the time an antibiotic had been administered by the nurse compared to the time it had been prescribed by the prescriber. Staff did not always ensure critical medications were given in a timely manner. The service undertook a consistency of care audit which showed that critical medicines were given 66% of the time, on average from 04 April 2022 to 13 April 2022.

We found patients who had been given an injection to calm or lightly sedate them did not always have their observations checked in accordance to the hospital policy. During our previous inspection in September and October

2021, we raised concerns to the trust with regarding rapid tranquilisation. The service provided details of the immediate actions to improve compliance against the trust's guidance. However, on 19 April 2022, in the emergency department we observed a patient who had been given rapid tranquilisation and had not been monitored appropriately following the trust and NICE guidance. On 20 April 2022, we saw a similar incident occurring in the medical care core service. The trust did not have an effective system to ensure that patients requiring rapid tranquilisation were assessed and monitored appropriately and were safe from harm. Therefore, on 22 April 2022, we imposed urgent conditions under Section 31 of the Health and Social Care Act 2008 to ensure the trust improves care and treatment of those who have been given rapid tranquilisation.

Staff did not always store and manage all medicines safely. During inspection, we observed prepared and unprepared intravenous fluids left unattended on work desks in the department.

Staff did not always follow policies when medicines fridges were outside the range. During inspection, we observed that one of the medicine fridges was outside the safe temperature range for three consecutive days. On the first day where it was documented as out of range, the temperature probe was reset as per policy. However, the fridge was still showing to be out of temperature range. Staff told us that the out of range temperature should have been escalated on the first day it was seen. We were told the service would be ordering a new temperature probe. Policies were not always being followed by staff when medication fridges went out of temperature range. This could expose patients to a risk of harm.

Incidents

The service was beginning to embed a better process for managing patient safety incidents. Managers were investigating incidents but did not always robustly identify lessons to improve patient safety. When things went wrong, staff apologised and gave patients honest information and suitable support. However, staff did not always recognise and report incidents and near misses appropriately. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

We saw that learning from significant incidents was not embedded and changes were not always fully implemented to mitigate risks to patients. However, the service had developed a more robust system and process since our previous inspection. The service had made improvements in their incident management policies and procedures, learning from incidents and incident management governance processes. However, these had not had time to fully embed and mature.

Staff received feedback from investigation of incidents, both internal and external to the service. From November 2021 to January 2022, 67% of the 61 staff who responded to the emergency department survey said they received feedback on lessons learned following serious incidents.

Managers shared learning with their staff about incidents that had occurred within the department and across the trust. During inspection, we observed posters sharing lessons learnt in the paediatric area within the emergency department. After the inspection, we were sent six emergency department lessons learnt newsletters which contained learning from incidents of prescribing errors. This was an improvement from the last inspection.

Managers shared learning about never events with their staff and across the trust. From January 2022, the trust started sharing learning through the safety focus newsletter. We saw newsletters contained incidents including delays in histology samples, learning from a misplaced nasogastric tube and support for patients who had recently given birth. We saw that lesson learned were shared in a variety of ways. The trust shared learning through a QR code, which was a barcode accessible by mobile telephones, that contained links to videos of a re-enactment of the incident. This was an improvement since the last inspection and an innovative way to share incidents.

Urgent and emergency services

We saw improvements since our last inspection. Divisional leaders held daily incident review meetings to discuss the incidents which occurred in the last 24 hours. These meetings were not formally documented but an action list was created to monitor required next steps for each incident discussed. These meetings consisted of reviewing the incident harm level and whether further investigations were required.

Leaders told us they understood duty of candour requirements. We reviewed some duty of candour letters and they were open and transparent and gave patients and families a full explanation if and when things went wrong. Since our last inspection the service told us that they had made improvements to monitor duty of candour compliance. We were told that within the integrated medicine and patient flow (IMPF) division duty of candour was monitored within the daily incident review meetings. However, this was not evident in the incident weekly trackers reviewed, action logs, planned agendas or the divisional quality assurance committee meeting minutes. We requested but did not receive evidence that the division monitored duty of candour compliance. However, duty of candour was monitored trust wide.

There was not always evidence that changes had been made as a result of feedback. The service's survey from November 2021 to January 2022 showed that 59% of staff felt that lessons were not always shared and embedded.

Staff did not always raise concerns and report incidents and near misses in line with trust policy. During inspection, we saw two incidents while in the department; one patient fell in the waiting room and one patient was trapped in the bars of a trolley. No harm occurred but there was a potential for harm. Neither of these incidents were reported. This meant the service could not learn from the incidents to prevent similar incidents occurring. We requested but did not receive evidence that staff were reporting incidents when patients received rapid tranquilisation, as per the trust's policy. Instead, the service described the new changes that would be undertaken after we imposed urgent conditions under Section 31 of the Health and Social Care Act 2008 to ensure the trust improves care and treatment of those who have been given rapid tranquilisation.

From 19 April 2021 to 20 April 2022, the service had five serious incidents. Four of these incidents were related to the care of deteriorating patients. We did not see evidence within the three 72-hour reports reviewed of robust identification of lessons learned. Therefore, early identification of lessons and appropriate support and feedback to staff to maintain safety was not always taking place.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. At the time of our inspection, there was no sepsis policy or clinical guidance in place at the trust to aid staff understanding in the identification, escalation plan and management of patients with suspected or confirmed sepsis. The trust had a modified sepsis pathway in place and a modified sepsis in adults checklist to aid in documentation of care and treatment. However, the trust's sepsis pathway and pathway checklist were not aligned and did not fully follow the NICE sepsis guidance.

In April 2022, the modified sepsis pathway contained three of the 10 recommended moderate to high risk criteria, and four of the eight high risk criteria. The trust's pathways did not contain all of the additional risk factors.

The pathway checklist contained all of the recommended high-risk criteria but only four of the 10 moderate to high risk criteria. The checklist did not include any of the additional five risk factors to consider. Therefore, we were not assured that the provider had an effective system in place for managing and responding to patient risk to ensure all service users who present with suspected or confirmed sepsis were cared for in a safe and effective manner, which could lead to harm to patients. In light of the enforcement action taken, the trust told us they published new pathways that were aligned to the NICE guidance on 9 May 2022.

The trust had a recognition and management of sepsis in children under 17 years old policy, which was approved in February 2021. The policy and screening tools followed the NICE guidance.

During our inspection, we saw local emergency department guidance for the management of cauda equina within the emergency department. However, the guidance did not include time periods for returning and no clear follow up mechanism which could lead to harm. After our inspection, the service shared the different pathway to the guidance seen on inspection. The Healthier Lancashire and South Cumbria pathway for MRI scans for cauda equina, was agreed in June 2020. This described that if a patient presented with signs and symptoms of cauda equina depending on the examination, a patient should either have a scan as an emergency or within 24 hours. However, during inspection we did not see that staff had access to the Healthier Lancashire and South Cumbria pathway in the emergency department. This meant that patients requiring urgent treatment may not always be recognised in a timely manner.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They did not always use the findings to make improvements and to improve outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Managers did not always use information from the audits to improve care and treatment. The service shared the results of the consistency of care daily audit from 02 March 2022 to 03 May 2022. Over the time period, compliance with the eight measures varied per day. On average over the time period, one criteria assessment measured 90%, the other seven criteria were below 85%. There was no evidence that managers shared the audits and used the results to improve care and treatment.

Since August 2021, the trust took part in a monthly sepsis audit through a north west quality improvement project. There was no sepsis audit data available specifically for urgent and emergency care. The trust monitored compliance against seven sepsis clinical pathway indicators. The monthly sepsis audit compliance scores for November 2021 (51%), December 2021 (42%) and January 2021 (39%) showed there was a worsening trend in overall compliance in sepsis management across the trust. This was significantly below the trust target of at least 75% compliance.

The audit data also showed the trust achieved the lowest year to date compliance score when compared with the 13 other NHS trusts across the North West region. Therefore, leaders could not be assured that staff were appropriately recognising and starting sepsis treatments within the recommended timeframes.

Outcomes for patients were variable and did not always meet expectations, such as national standards. The service participated in relevant national clinical audits. The trust participated in the Sentinel Stroke National Audit Programme (SSNAP) audit which showed from October to December 2021, the overall score reduced from B to D. The audit showed that at Blackpool Victoria Hospital a lower percentage of patients had a Computed Tomography (CT) scan within one

hour of arrival when compared nationally. In addition, 50% of eligible patients were thrombolysed, which was worse than the national average of 83%. This meant that the significant pressures in the emergency department meant that patients may not be recognised as having a possible stroke in a timely manner. We requested but did not receive an action plan to improve stroke management and outcomes. However, once a diagnosis of a possible stroke was made a higher percentage of patients, when compared nationally, were receiving appropriate screening assessment within four hours for ensuring they were safe to swallow. This meant that accident and emergency staff were ensuring patients had appropriate risk assessments.

The service regularly participated in Trauma Audit and Research Network (TARN). From January to March 2022, out the 14 TARN measurements; five were better than expected, five were worse than expected, and four of the measurements were similar to the national average.

The service had a similar risk of re-attendance compared to the England average. The service saw 8% reattendances in March 2022. The service had monthly multi-agency group meetings to discuss frequent attenders to the emergency department to ensure support was in place. The patients who attended frequently were flagged on the electronic system to alert staff that management and support plans were in place.

Competent staff

The service did not always demonstrate staff were competent for their roles. Managers did not always appraise staff's work performance and held supervision meetings yearly to provide support and development.

Staff were qualified but the service could not always demonstrate staff had the right skills, experience, and knowledge to meet the needs of patients.

The recognise and act course was a mandatory course for registered and unregistered nursing staff who cared for patients, including staff in the emergency department. A more medicalised version of recognise and act training was delivered to junior medical staff as part of their induction period. We were told the recognise and act training was mandated to be renewed every three years. The recognise and act course was based on the NICE guidelines for acutely ill adults in hospital: recognising and responding to deterioration (CG50). Staff were not always being trained on all the up to date evidence-based care and treatment for the management of sepsis.

Compliance rates for the recognise and act course were almost aligned to the trust's compliance rate of 95% for nursing staff that compliance rates of 89%. The service's compliance figures for medical staff was not provided. Therefore, this meant that staff were not receiving training on identifying, escalating and managing patients with signs and symptoms of suspected or confirmed sepsis.

Managers were aware nursing staff did not always have opportunities to develop through regular, constructive clinical supervision of their work. Appraisal rates were at 51% compliance for registered and unregistered nurses who work in the adult areas within the department and were at 80% for the children's registered and unregistered nurses. Leaders had created an action plan to manage and ensure these were completed.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. In April 2022, medical staffing appraisals were at 95% compliant.

Urgent and emergency services

The service provided triage training in a modified Manchester triage system training. In April 2022, 61% of nursing staff were trained in triage and 13% had not completed triage training but were scheduled to complete the course. The other 26% of nursing staff were not identified to be trained in triage due to inexperience in the department. The requirement was that nursing staff needed to work in the department for one year before undertaking the training.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs. The service did not consistently maintain patients' privacy and dignity.

Patients said staff treated them with kindness. We observed that staff were kind and caring when speaking with patients. Relatives and carers were encouraged to be involved in the care and treatment of their relative.

Staff were not always responsive and did not always have the time to interact with patients and those close to them due the significant pressures within the department. Patients waiting for care and treatment told us they felt like staff were not always aware who patients were. In addition, patients told us they were not sure if those close to them were aware or had an understanding about their care and treatment.

Staff did not always follow policy to keep patient care and treatment confidential. We observed medical assessments taking place in the corridor, other patients nearby were able to overhear assessments. Due to the pressures on the service there was not always appropriate cubicle spaces to undertake medical assessments in a timely manner.

We saw that patients had lengthy stays in the department resulting in them being sat in chairs for extended periods of time as there was no beds or trolleys available for them to use. On 19 April 2022, we saw one patient who had been on a waiting room reclining chair for 24 hours. Patients told us they had not been offered pillows and blankets overnight and were not always kept informed about their care and treatment. Managers were aware of this and had sought to find more suitable arrangements. This was not possible due to the pressures on the service and the lack of available bed space.

Is the service responsive?

Inspected but not rated

Access and flow

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

The service had 43 trolley spaces in the emergency department. During our inspection, on 19 April 2022, we observed the department had from 86 to 106 patients in the department at any one time. This significant increase in patients within the department had been a regular occurrence.

Urgent and emergency services

Managers did not always monitor and ensure that patient moves around the department were kept to a minimum. Patients told us they waited prolonged periods of time in ambulances and had multiple moves around the department.

To manage the extra capacity of patients arriving to the department, the service told us they had created 19 escalation spaces within the emergency department for trolleys, these were located in the corridors. Although this was in place, there were additional patients with ambulance crews waiting to handover their care; these were located in the middle of corridors and additional identified spaces. We observed patients being transferred from ambulance stretchers onto hospital trolleys in entrances and corridors. This meant that the service was significantly overcrowded and that risks could not always be managed and mitigated completely. This also compromised the privacy and dignity of patients.

In March 2022, the service developed a standard operating procedure (SOP) with the local NHS ambulance service called "Delay to transfer into the emergency department". The SOP included cohorting up to six patients waiting with one ambulance crew into a designated escalation area. This enabled up to five ambulances to become available to attend patients waiting in the local community.

The escalation area identified was an x-ray waiting room called X-ray North. We observed during inspection, there was access to one hospital resuscitation trolley with a defibrillator. However, it was not immediately available and we did not see sign posting specifying the location. The waiting room did not have piped oxygen available but bottled oxygen was provided when required. The waiting room did not have call bells or emergency alerting alarms. There was a risk that if a patient deteriorated there may not be access to emergency equipment in a timely manner.

The decision to open the escalation area for X-ray North was made by the ambulance regional operational control centre, prompted by the hospital. The decision was considered when the emergency department was above capacity with over 100 patients in the emergency department.

The service provided evidence from February 2022 to April 2022, that X-ray North had been utilised as an escalation area on 24 occasions. In total the area had been used for 272 patients; the average amount of time patients spent in this area was two hours and nine minutes. The SOP defined the escalation exclusion criteria as any patient with a NEWS2 score of greater than four, oxygen requirements of more than two litres, patients with infections and patients at the end of their life. However, this meant that risk assessments for patients cohorted in x-ray north were not documented. Senior ambulance staff had the responsibility to wait with the patients until care and treatment could be provided by the hospital. Despite the patient being the responsibility of the emergency department when they arrived.

From February 2021 to February 2022, the trust failed to meet the national standard of 95% of patients being admitted, transferred or discharged within four hours of arrival which was similar to national figures. On 19 April 2022, we observed the longest waiting time for admission to an internal bed within the hospital to be 39 hours and 41 minutes. In addition, we observed a patient waiting for 44 hours and 41 minutes for an external inpatient mental health bed, which was not provided by Blackpool Teaching Hospitals NHS Foundation Trust.

Nationally since the COVID-19 pandemic began in 2020, the number of patients waiting more than 12 hours from the decision to admit (DTA) until being admitted had followed the national, rising, trends until April 2021. Then the gap between the national average and Blackpool emergency department increased, meaning more patients were waiting longer for admission beds. The monthly number of patients waiting over 12 hours from a DTA increased through the year from 61 in August 2021 to 928 in April 2022. This was an increase of 175%, which was higher when compared nationally. From January 2021 to January 2022, there was a national increase of 125% for delayed DTA to admission figures.

Urgent and emergency services

The board signed off the full capacity protocol in March 2022, which was an addition to the trust's escalation framework. Between February 2022 and April 2022, the full capacity protocol was enacted 25 times. This included the use of whole hospital as well as escalation actions within the emergency department.

We observed the full capacity protocol in process on 20 April 2022, 15 patients were moved from the emergency department within one hour. The process involved the same escalation exclusion criteria as discussed in the ambulance escalation. The full capacity protocol involved a three-stage process, the first stage involved patients being moved out from the acute medical unit (AMU) to another 'holding area' or non-bed space in the hospital. The second stage was the emergency department moved an allocated number of patients to AMU. The third involved orthopaedic, surgical and cardiology patients being assessed in the emergency department and directed into a bed or a corridor space on the appropriate wards.

Staff told us that the locally known 'surge protocol' worked at the time of extreme capacity to create immediate space. The surge protocol was monitored locally in the emergency department through the electronic computer system. However, we did not see formal documentation or risk assessments within the patients' records to ensure patients were safe to be escalated at times of extreme pressure. The clinical site matrons logged daily activity across the trust and decisions made around site management included details of the full capacity protocol implementation. Executive directors had oversight and were involved in the decision making to initiate the surge protocol through the morning flow meetings. Clinical site matrons monitored the surged patients to ensure they all had suitable beds by night-time.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood but did not always have resources and space to manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Leaders had the appropriate range of skills, knowledge, and experience to carry out their roles. The emergency department was part of the division of IMPF. There was a triumvirate leadership team for the division which included a divisional medical director and divisional director of operations. Since our last inspection there was a vacancy for the divisional director of nursing; one of the deputy directors of nursing for the trust had undertaken the role until the vacancy was filled.

We observed the triumvirate leadership team in the department during busy times throughout our inspection. At times the department felt significantly overcrowded but staff seemed calm.

The department leaders were able to tell us about the main risks within the department and the long-term plans for change. Since our last inspection, the service had developed an emergency department improvement plan to monitor and improve the service.

Staff were allocated areas of responsibility for each shift. Challenges occurred when the department was short staffed or became busy and staff had to support other areas in the department. The COAST accreditation scheme identified that there was limited evidence of strong leadership during shifts. COAST recommended that coaching for coordinators was required to ensure a consistent approach to patient care. We did not see this as an action in the emergency department action plan and there was no associated COAST action plan.

Culture

Staff felt extremely stressed and they told us the constant high demand impacted the care they would like to provide. They were focused on the needs of patients receiving care. The service had started to build an open culture where staff could raise concerns without fear.

Leaders told us that the staff were stretched to their limits and were extremely stressed. Leaders were doing all they could with limited resources to support staff. However, this was affecting timeliness of management office work such as reviewing incidents. We saw staff working extremely hard, in challenging situations to attempt to manage the pressures and risks the service faced.

Staff were concerned about how the demand on the department was impacting the care they would like to provide. We saw that staff of all levels and from different areas worked as a team and supported each other during busy periods with limited resources. Staff felt listened to but did not always have the information required to ensure continuity of care for patients.

Staff told us debriefs were held following distressing cases to offer support to staff. They also told us the trust wellness team offered opportunities to talk and phycological support when needed.

During inspection, we observed the freedom to speak up guardian visiting the emergency department; we were told this was to increase accessibility and visibility for staff; they had been to the department on four occasions, to establish and build relationships. We were told that staff had raised concerns safely, and confidentially, during these meetings and that staff felt a weight had been lifted. The guardian had established improvements to relieve some of the pressure staff were feeling. We were told that this had been welcomed by staff. This was an improvement since our last inspection and was assisting to embed a safe speaking up culture.

Governance

Leaders were beginning to operate effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities but did not always develop effective plans to learn from the performance of the service.

The division had re-organised their divisional governance meetings to reflect the board structures since our last inspection. The service undertook quality assurance meetings and clinical effectiveness and mortality meetings every six weeks.

Managers did not always investigate and implement changes to improve care when audits showed poor compliance rates. Within the divisional quality assurance committee meetings for January 2022, it was noted that sepsis showed poor compliance overall. Leaders suggested that doctors could be encouraged to implement the pathways on admission to improve compliance. From the 1 March 2022 divisional quality assurance committee notes, it was minuted that “the sepsis pathway was poorly implemented especially in the emergency department”. There was no evidence of discussion of how to improve compliance.

We saw that performance was not always monitored and audit activity was not always completed as planned. The service was accredited by COAST. The emergency department was accredited on 17 March 2022 and rated as Bronze. This was the same as rated previously in November 2021. The service had not developed a COAST action plan to improve the accreditation ratings.

The emergency department improvement action plan was monitored on a daily basis by senior leaders in the emergency department. Weekly the divisional triumvirate met informally to discuss the action plan and identify areas required for support. The emergency department senior leaders and divisional triumvirate met the executive team to provide progress on the action plan. We noted updates were documented on the action plan.

Management of risk, issues and performance

Leaders and teams used systems to manage performance but did not have the resources and support to manage risk. They identified and escalated relevant risks and issues but did not always identify actions to reduce their impact in a timely manner.

We were told by staff and leaders that the trust was experiencing unprecedented pressures. The trust was on Operational Pressures Escalation Level (OPEL) four during our inspection. This is based on the national framework and is the highest operational pressure level leaving organisations being unable to deliver comprehensive care; there is increased potential for patient care and safety to be compromised.

Leaders had oversight and were monitoring the access and flow risks facing the department. However, leaders had limited opportunities to create space to improve access and flow. Local leaders escalated appropriately when there was overcrowding and were supported by senior leaders within the department.

Since our last inspection, senior leaders had created the full capacity protocol in March 2022. This was used when the department was significantly overcrowded; the intention was to share the load and the risk throughout the hospital rather than solely within the emergency department. Senior leaders regularly met with the integrated care system and requested mutual aid. However, the other NHS trusts in the system were in similar situations and could not offer support.

Senior leaders were aware of the concerns and had secured funding to build a new emergency village and allow for expansion of the emergency department. The service had also commissioned an external company to review the emergency department and offered support on improvements to develop the department, the report was presented to the service in January 2022. This was an ongoing workstream to improve the emergency department services.

Managers and staff told us they felt urgent and emergency care were holding a significant amount of risk for the health and social care system across the county which was having a potential impact on all staff and patients. Leaders were not always able to have confidence that risks could be appropriately managed and mitigated.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of the impact giving a red, amber, green (RAG) rating.

The divisional risk register showed that the leaders were aware of the risk of the failure to provide consistent safe nurse staffing levels in the emergency department. Leaders had put some control measures in place to mitigate the inconsistency of nurse staffing. Within the risk register it stated that the safe staffing model was completed and sent to the executive team for financial approval on 21 January 2022. We saw that in June 2021, leaders undertook a

professional judgement review and update on recommended uplift in staffing to the board but this did not include emergency department staffing. Leaders told us they had not presented the increased nursing staffing establishment for the emergency department to the board for funding approval. This meant that leaders did not act in a timely way to mitigate staffing issues within the department to protect staff from burn-out and ensure patient safety.

Local leaders in the department undertook the consistency in care audit. We were provided with an action plan to address the eight categories assessed to improve compliance, all but one were being implemented at the time of our inspection.

Outstanding practice

We found the following outstanding practice:

- Using different technologies to share incidents to prevent similar incidents re-occurring. We observed the trust sharing QR codes with links to video re-enactments of incidents to help staff to learn from incidents.

Areas for improvement

MUSTS

Blackpool Victoria Hospital urgent and emergency care core service

- The service must ensure that they have sufficient numbers of suitably qualified, competent, skilled and experienced persons. (Regulation 18 (1)).
- The service must ensure that health and safety risks to service users are assessed when receiving care and treatment (Regulation 12 (1) and (2) (a)).
- The service must ensure that staff are doing all that is reasonably practicable to mitigate any such risks to ensure care and treatment is provided in a safe way for service users (Regulation 12 (1) and (2) (b)).
- The service must ensure that systems and processes are established and operate effectively to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity (Regulation 17 (2) (a)).
- The service must ensure that systems and processes are established and operate effectively to assess, monitor and mitigate the risks relating to health, safety and welfare of service users (Regulation 17 (2) (b)).
- The service must ensure that they evaluate and improve their practice (Regulation 17 (2) (f)).

SHOULDS

Blackpool Victoria Hospital urgent and emergency care core service

- The service should ensure that it improves mandatory training including basic life support, safeguarding and infection prevention and control training.
- The service should ensure that staff have enough suitable equipment to care for patients safely, including drip stands.
- The service should ensure all patients with infections are isolated appropriately.

Urgent and emergency services

- The service should ensure that equipment is checked daily, including emergency equipment and fridges holding medicines.
- The service should ensure that procedures are followed when fridge temperatures are out of range.
- The service should ensure that all staff have appraisals yearly.
- The service should ensure there is appropriate leadership and responsibility in areas within the emergency department during shifts.
- The service should ensure that changes in staffing requirements are escalated to board in a timely manner.
- The service should ensure that critical medicines are given in a timely manner.
- The service should consider how patients can access washing facilities when in the department for long periods of time.
- The service should consider how patients can call for assistance when in escalation spaces within the department for long periods of time.

Surgery

Inspected but not rated

The trust delivers its surgical services at Blackpool Victoria Hospital (BVH). The surgical services are managed by the division of surgery, anaesthetics, critical care and theatres (SACCT) and the division of tertiary services. The two divisions were formed by the trust in April 2021 and both divisions have a separate senior leadership team (SLT).

The division of SACCT provides non-elective, elective and day case surgery for several surgical specialities. These include general surgery and specialist surgery. The specific services include ear, nose and throat, oral, maxillofacial, audiology, orthodontic, orthopaedic, ophthalmology, urology, colorectal, breast, plastic and podiatric surgery.

The division of tertiary services provides specialist non-elective, elective and day case surgery for cardiothoracic surgery.

Hospital Episode Statistics showed that the hospital from June 2020 to May 2021 had the following number of surgical activities between this period:

- 2,772 elective admissions
- 6,791 emergency admissions
- 9,237 day admissions

At the last inspection in October 2021, the surgical services received an overall rating of requires improvement. The surgical services were rated as requires improvement for being safe, effective, and well-led and were rated good for being caring. Responsive was rated as inadequate.

We inspected the surgical services between 19 and 20 April 2022. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

This inspection was undertaken to review the Section 29A warning notice that was issued on 25 October 2021. The warning notice was issued based on concerns specifically relating to;

1. The trust were not effectively or appropriately assessing and managing the risks to patients who were waiting to receive care and treatment. The trust did not have effective systems to identify and reprioritise patients based on changes to their presenting risks. See the operational performance section below for further detail.
2. The trust did not have effective systems and processes to ensure incidents were reported, reviewed, and investigated appropriately to ensure lessons were identified and shared with teams. See the incident section below for further detail.

For this inspection we considered information and data on performance for the surgical services but did not re-rate the service.

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents, shared lessons learned and apologised when things went wrong.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were comparable to other trusts across the region.

Surgery

- The service had developed a new formal governance structure for monitoring patient waiting lists and referral to treatment times. From evidence provided by the trust and discussions with service leaders we could see that improvements had been made in both the method of recording and monitoring of waiting lists since the previous inspection. All staff were committed to continually learning from incidents and improving services. The service had undertaken a review of serious incident reporting and had identified an organisational action plan relating to serious incidents.

However,

- Due to the effects of the COVID-19 pandemic not all people could access the service when they needed it.

The service had outdated had outdated IT software, which aided in data quality concerns but were in the process of updating the system. The trust had undertaken a review of their duty of candour processes and had found a lack of documentation evidence of duty of candour. The trust had updated their duty of candour policy.

Is the service safe?

Inspected but not rated

Incidents

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

Following our previous inspection of the trust from 14 September 2021 to 20 October 2021, we issued a trust-wide Section 29A warning notice which related to concerns about the management of incidents. After issuing a section 29A warning notice the CQC was required to reinspect the trust to ensure improvement have been implemented effectively. We returned to follow up on concerns within the warning notice and found that the trust had changed their processes and were on a journey to improvement when considering the management of incidents.

At the last inspection the trust did not have effective systems and processes to ensure incidents were reported, reviewed and investigated appropriately. At this inspection, the trust had reviewed the incident reporting policy, created an incident management standard operating procedure and had defined a ward to board process for the management of incidents.

There was a new clinical governance committee structure that was due to commence in May 2022. There was evidence in the Quality and Clinical Effectiveness Committee (now known as the Quality Assurance Committee), that there was oversight of the numbers of open incidents across the trust, which included how many had breached their target for closure.

At the October 2021 inspection, there were 1,469 open incidents across the trust. This compared with 1,769 open incidents across the trust on 7 February 2022, with 316 of those having breached their timescale for closure. This demonstrated that there was an increase in the number of open incidents. However, the service had developed a more robust system and process since our previous inspection. The service had made improvements in their incident management policies and procedures, learning from incidents and incident management governance processes. However, these had not had time to fully embed and mature.

Surgery

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the trust policy.

Staff at various grades, including students, were able to provide examples of incidents reported and described the process followed to raise them. They talked in a positive manner about the process and the feedback that they received from lessons learned.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff gave examples of incidents where duty of candour was applied and the actions, they would take should they feel this was required. From the evidence provided by the trust we saw that duty of candour processes had been followed where required, with patients or their representatives being included in discussions.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff were confident that learning was being shared and told us they received feedback regarding incidents in a variety of ways such as by direct emails, newsletters or at staff huddles and staff meetings. There was a lessons learnt newsletter. This detailed the incident, identified learning and improvement actions. Staff also told us about closed/private social media groups that they used to share important information and learning from incidents. We saw staff huddle folders contained copies of recent incident reports which were to be discussed at the next huddle. In some wards we saw staff information boards with themes and trends from incidents identified and educational material to support learning.

Where staff had been involved in, or reported an incident, the outcome would be discussed with them individually as well as any learning being shared with other staff.

Learning from incidents in other areas of the trust was also shared with staff to allow any changes to be made in other wards.

Staff met to discuss the feedback and look at improvements to patient care. We were informed of a 'focus of the day' meeting on Ward 35, where staff could discuss learning and suggest any actions that may prevent further incidents or improve patient care.

On the Lancashire Suite staff told us they had completed a strengths, weaknesses, opportunities and threats (SWOT) analysis to identify ways to improve performance and help prevent future incidents.

Managers investigated incidents thoroughly. Staff told us that where the level of harm was rated as moderate or above the risk management team would review the incident details and direct the staff as to what level of investigation was required.

Ward sisters or matrons told us they tried to investigate incidents promptly and we were told that, where possible, they would aim to investigate and resolve no harm/low harm incidents before patients were discharged.

Is the service responsive?

Inspected but not rated

Surgery

Access and flow

Due to the effects of the COVID-19 pandemic not all people could access the service when they needed it. However, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were comparable to other trusts across the region.

In evidence provided by the trust there were 25094 patients with incomplete pathways (either awaiting appointments or with future appointments). In line with national directives the trust told us that all patients who had been waiting over 104 weeks for an appointment should receive their appointment date before the end of June 2022. All patients waiting over 52 weeks for treatment received a clinical reviewed and these patients were reported to the quality committee on a quarterly basis.

Managers worked to keep the number of cancelled operations to a minimum. We saw that, despite 16 of the 24 day case beds being taken up by the escalation bay, no patients had their surgery cancelled on that day. Staff told us there would only be eight beds utilised for escalated patients. In order to ensure the appointments were not cancelled a variety of methods were employed such as keeping patients in the recovery area for longer, until they were well enough to be moved to a chair.

Staff told us the situation had been fully escalated that day and work had been undertaken to reduce the number of escalated patients taking up the additional beds.

Staff on the day case unit felt that, although they were working hard to undertake as many surgical procedures as possible, the lack of space meant that waiting times for surgical patients were not reducing as fast as they could be.

Staff also told us that, to help reduce waiting times for surgery, some less complex cases were being seen by another local hospital.

In evidence provided by the tertiary services division the cardiothoracic surgery team were holding a weekly scheduling meeting. This was a multidisciplinary meeting where issues from the current week and an overview of the next two weeks planned theatre cases were discussed, as well as potential issues that could be addressed through scheduling.

A Theatre Efficiency Steering Group was held once a month. This was a multidisciplinary meeting where the reasons for theatre cancellations were reviewed and plans to address any issues discussed. Examples of this were improving escalation procedures, looking to have a dedicated theatre coordinator, rather than a current shared role on a rota, with the aim of improving consistency.

Within the surgical division a variety of quality control measures had been introduced to ensure theatres were utilised efficiently, and theatre lists were running to time. In evidence provided by the trust we were informed that a task and finish group was to commence in May 2022 to focus on the reasons for on the day cancellations and to find solutions to help reduce these.

Evidence provided by the trust indicated that the main cause of cancellation was overrunning theatre lists (30%) followed by lack of beds (23%).

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. Information provided by the trust showed that across the surgery core service, in the six months prior to the inspection, 305 patients had their appointments cancelled and that 81% of those patients had been rebooked within 28 days of their cancelled appointment.

Surgery

Of the patients being rebooked the clinical area with the highest compliance in relation to the 28 day target was urology at 95% followed by cardiothoracic at 94%. The clinical area with the lowest compliance was ear, nose and throat (ENT) with a compliance rate of 33%.

Is the service well-led?

Inspected but not rated

Data quality

Senior leaders explained they had contracted a data quality external company to undertake an external review of their waiting list and, where data quality issues were identified, provide an action plan to improve processes and data validation.

The main cause of the data quality issues was outdated IT software, with an old version of a record management system causing significant difficulties. The trust told us they were in the process of upgrading or replacing the system ahead of the introduction of the electronic patient record system.

The external review identified issues with the management of the waiting list data. The trust explained they were in the process of restructuring the data validation team and recruiting additional staff to work in the team.

In addition, to assist in upskilling data validation staff, and as a means of training new staff, the external company had also produced a training package which would become a mandatory training module for all staff whose role involved data validation and accessing waiting lists.

We saw the new waiting list data format, allowed a much clearer picture of patients waiting for treatment, those who were on the list and had received appointments and those who were waiting but had not yet received an appointment.

The trust advised they were planning to improve this further by having three separate waiting lists for outpatients, booked planned and inpatients, which assist in the monitoring and scheduling of these patients.

Governance

We were told that the trust now had a formal governance structure in place for monitoring the patient waiting lists and referral to treatment times. There was a weekly divisional patient tracking list (PTL) meeting which fed into the corporate PTL meeting. This allowed oversight of the current waiting lists and discussion of any changes to prioritisation.

Following the previous inspection, the concerns around incorrect priority coding of patients, and delays in treatment of priority one patients (P1 patients should be seen within 72 hours) was investigated. It was found that the software system was incorrectly allocating P1 status to any cancelled appointments. This issue was resolved and the profile of P1 reporting within divisions escalated. Priority coding was added to a revised assurance and escalation agenda and we were told that as of 3 January 2022 the number of P1 patients on the PTL had dropped to single figures for the first time.

The trust told us that any P1 patients identified were escalated and their status reviewed and amended if required, or the patient was booked for their procedure in line with the clinical urgency.

Surgery

Harm reviews

The trust provided an updated policy for harm assessment and reviews for long waiting patients and potential re-prioritisation in line with the updated national guidance. This document, 'Referral to Treatment – Patient Harm Review', highlighted the arrangements undertaken to ensure that patients waiting for treatment were adequately assessed for any potential harm resulting from their extended wait for treatment and, if required, reprioritised.

The trust confirmed that they had initially undertaken harm reviews for all patients who had been on the waiting list for 52 weeks or over, however, in line with national guidance, their harm review policy had now been amended to review patients who had been waiting 78 weeks or over.

Whilst this initial review had been completed the trust was aware there was also a need to monitor all patients on the waiting list who were not classed as urgent or had waited over 78 weeks. They described potential options that they were considering going forward, such as telemonitoring for patients awaiting cardiac procedures and automated telephone calls which allowed patients to flag if their condition had worsened and this would trigger a review.

The trust had introduced a live harm review tracker. The tracker showed that, in November 2021, all patients waiting over 52 weeks on an elective waiting list had received a clinical harm assessment; 934 harm reviews had been completed. Out of the 934 there were 632 cases where no harm had been identified, 221 low harm and 81 cases of moderate harm, for which a separate tracker had been introduced so these patients could be monitored individually.

From evidence provided by the trust and discussions with service leaders we could see that improvements had been made in both the method of recording and monitoring of waiting lists since the previous inspection. The trust was sharing learning from the waiting list review with other trusts across the Lancashire and South Cumbria integrated care system to feed into work around system recovery across the region.

Learning, continuous improvement and innovation

All staff were committed to continually learning from incidents and improving services.

Following the inspection in October 2021 a Section 29a warning notice was issued in relation to the trust not having effective systems and processes in place to ensure incidents were reported, reviewed, investigated appropriately, and that lessons were identified and shared with teams. At this inspection we reviewed the actions taken since the warning notice was issued.

In evidence provided by the trust, we saw that the division now had a process in place for monitoring and investigating incidents, with both divisional and board oversight. We saw that incidents of concern were escalated appropriately. Incidents graded as moderate harm and above were added to an internal divisional dashboard which was managed by a divisional quality team, with requests for reviews sent to the appropriate staff, along with the necessary templates to complete.

We were told that the trust had employed a new clinical incident manager in the corporate quality governance team who reviewed all incidents and levels of harm to ensure that they were correctly graded. The clinical incident manager had weekly meetings with the divisional quality managers to review incident data. We were told that the trust had employed a new clinical incident manager in the corporate quality governance team who reviewed all incidents and levels of harm to ensure that they were correctly graded. The clinical incident manager has weekly meetings with the divisional quality managers to review incident data. We were told there was a daily divisional review of all incidents rated as moderate harm or above, with a member of the triumvirate reviewing incidents weekly, looking at the level of harm and duty of candour.

Surgery

Senior leaders told us that following a review of incident investigations they had determined that it was taking managers longer than 72 hours to complete initial investigations in many cases, partly due to the design of the investigation template which had led to staff undertaking investigations that were more like a mini root cause analysis. As a result, they had stripped back their 72 hour investigation template after agreeing the level of investigation required at that stage.

We saw the trust had introduced an incident management standard operating procedure (SOP) to provide guidance on how to manage incidents and the steps needed to complete a 72 hour rapid review. The SOP included a flow chart which outlined the incident reporting and investigation process.

Senior leaders also told us that they recognised the need to ensure equity across all divisions and it was intended that this new SOP would assist with this. They were also aware of the need to ensure that incidents graded as no harm or low harm needed to be monitored. They routinely reviewed a sample of these incidents to ensure that processes were followed and these were recorded on an action log.

Duty of candour (DOC)

At the previous inspection we found that the duty of candour process was not always being followed by the trust. Senior leaders told us they found that despite governance reports stating that the division had been 100% compliant with duty of candour, this was not accurate, and had now been reported to the Quality and Clinical Effectiveness Committee.

We were told that, following a review of historic investigations, dating back 12 months from 14 February 2021, it had been determined that although processes had in many of the cases been followed (95%), there had often been a lack of documentation to evidence this.

Where processes had not been followed one of the common failures (13%) was the issuing of a formal duty of candour letter following the initial conversation with the patient and/or their family. We were informed that, going forward, there was to be a retrospective audit of the DOC final letters as well as weekly live monitoring of the investigations subject to duty of candour.

We saw that an updated duty of candour policy had been produced, which was in line with the CQC duty of candour guidance. The trust had also produced a DOC flowchart and briefing paper and in addition had produced educational material to educate staff around the DOC process. The leadership team told us the changes in the 72-hour incident investigation template had assisted in reminding staff of the duty of candour process. The new template allowed completion of DOC to be reviewed for each incident and escalated where this had not been followed.

Serious incidents

At the previous inspection the CQC had raised concerns around the reporting of serious incidents. As a result of this, we were told, the trust incident policy had been updated and changes had been made to the serious incident reporting template.

The leadership team told us that following a review of serious incident reporting they had identified there was a gap in organisational actions relating to serious incidents. The service had introduced an organisational action plan following the warning notice to address the gaps relating to serious incidents.

We were told that all staff were encouraged to report an incident as a serious incident even when there was doubt that it met the threshold. All serious incidents reported were reviewed and, if needed, downgraded if the threshold was not met.

Surgery

We saw examples of situation, background, assessment and recommendation (SBAR) reports which were produced to highlight serious incidents. We were told these were shared with senior leadership teams to ensure they were aware of any serious incidents that had occurred within the service. We were told these had been very well received by the management teams and we saw these were included on the clinical governance meeting agenda for discussion.

The leadership team felt there was still a lot more they wanted to do to improve, including undertaking thematic reviews of serious incidents.

Learning from incidents

Senior leaders acknowledged that whilst information about incidents was shared across teams, trust wide, through safety huddles, SBARs and red alert bulletins, they also needed to look at ways to share the learning identified from these investigations.

We were told that work was being undertaken to refresh the trust's intranet page and in the future, there would be a specific learning page where SBARs, bulletins and newsletters could be viewed. We were told that a survey of staff had been undertaken to determine how staff wanted to review learning from incidents. The leadership team told us that as a result there was work being done to look at producing more learning and incident simulation videos and podcasts.

Our inspection team

Ann Ford, Director of Operations Network North chaired this inspection and Karen Knapton, Head of Inspection led it. The team included further inspectors and specialist advisers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	S31 Urgent variation of a condition