Southport and Ormskirk Hospital NHS Trust

Quality Report

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Southport and Ormskirk NHS Trust has two hospitals and a walk in centre and provides community services to a local population of 258,000 people across Southport, Formby, Sefton and West Lancashire. The health of people in Sefton is mainly worse compared with the England average. The trust is an integrated care organisation (ICO), delivering care in hospital and the community and employs approximately 3,242 staff of which 270 are medical, 1,052 are nursing and 1920 are other disciplines.

Acute care is provided at Southport and Formby District General Hospital and Ormskirk District General Hospital and had 23,084 admissions between September 2014 and August 2015. There are 497 beds, 455 General and acute, 27 Maternity and 15 Critical care.

We conducted a focussed follow up inspection of Southport and Ormskirk NHS Hospitals Trust between 8 and 11 April 2016. This was to review the progress of the trust following a previous inspection in November 2014 when concerns were raised. We visited Southport and Formby District General Hospital, Ormskirk District General Hospital and the Skelmersdale Walk in Centre. We also visited the community services for adults, end of life and children and young people's sexual health services.

We reviewed all the services across the trust including all the areas of concern which were raised at the previous inspection in order to assess any changes.

Overall the trust has been rated as requires improvement with significant concern for safety identified in the Accident and Emergency Department and the surgical services at Southport and Formby District General Hospital. However, there was improvement noted in both the maternity services and the North West Regional Spinal Injuries Centre which both received inadequate ratings at the last inspection.

Our key findings were as follows:

Vision, Strategy and leadership

At the time of the inspection the trust had been led by an interim executive team with the exception of the Director of Nursing and the Medical Director. Interim management arrangements had been in place for the eight months prior to the inspection following the exclusion of three directors including the Chief Executive Officer. The Trust Development Agency (now NHS Improvement) had been and were continuing to support the trust through this challenging period.

The interim team had begun to explore and develop options for the future to in line with national and regional initiatives to change the healthcare landscape in terms of the development of sustainable services, however, at the time of our inspection definitive outcomes had yet to be determined. This limited the trusts ability to demonstrate a clear vision and strategy for the organisation going forward.

Staff engagement had been foremost and the interim executive team had made considerable efforts to engage and be visible to staff at a range of engagement meetings.

There were significant failings within the governance processes of the organisation including a lack of Board oversight of all risks and inconsistent use of the committee structures to provide board assurance. In addition, the pharmacy governance arrangements would not clearly support the principles of the medicines safety alert 'Improving medication error incident reporting and learning, March 2014' with regard to identifying, developing and promoting best practice for medication safety.

This was the case despite two never events occurring that related to appropriate medicines management. At the time of our inspection there was no designated committee to lead on the review of medication errors throughout the Trust, and in the absence of a champion, a pilot initiative to collect data for the NHS Medicines Safety Thermometer had been discontinued.

Access and flow

There were significant concerns regarding the management of flow through the hospital despite the trust taking action to promote discharges earlier in the day to allow for admissions from the emergency department.

Summary of findings

There continued to be very poor performance regarding patients being seen within four hours in the A&E department with extensive waits for patients who remained in the supervision of the ambulance service for up to 11 hours. Percentage compliance rate against the 4 hour A&E wait differed between the two hospital sites with Ormskirk delivering at high percentages but the Southport site was performing at much lower levels. Over January 2016 Southport performed between 51% and 75% against the Ormskirk site performance between 99% and 100%. This meant that the trust wide performance was between 80% and 89% masking the very poor performance at the Southport site. Year-to-date performance at February 2016 was 92.9%, driven primarily by performance of 60.4% at Southport. February 2016 performance was 84.5% (53.7% in Southport).

The Trust continued to breach the ambulance handover target and performance remained poor with significant breaches in December 2015 and January 2016 (203 '30 minute', 271 '60 minute' up on December's 142 & 159).

We found elements of care for patients with sepsis that were worse than the regional average and in at least one case where the patients care had been poor. We also found that the recording and governance of this patients care was poor.

Other contributing factors included lack of bed space for planned admissions and a lack of escalation facilities at times of high demand. This meant that patients were often placed in areas unsuited to their needs or remaining in the A&E department for long periods of time.

We found that staff did not always assess monitor or manage risks to people who use the services and opportunities to prevent or minimise harm were missed. Medically deteriorating patients were not always identified promptly and when they were identified through the electronic EWS it was reported that out of hours there could be a delay before medical assessment was undertaken. We also saw evidence of a delay in the response time of the critical care outreach team to a patient with a high early warning score. We found that nutritional risk assessments were not always completed for patients who were clearly vulnerable. In addition fluid balance charts were not consistently kept updated on all wards.

The GP assessment area was used as an escalation area for medical patients and consequently there was underutilisation of ambulatory care. There were surgical patients waiting in the emergency department for assessment causing additional 4 hour breaches.

Patients on the acute wards waited for rehabilitation beds at Ormskirk DGH and there were delayed discharges of medically fit patients.

Nurse and midwifery staffing

The nursing and midwifery teams were positive about the impact of the Director of Nursing in terms of support and service improvement, however it was acknowledged that there was still much to do in terms of recruiting suitable and sufficient numbers of staff within both disciplines.

Recruitment and retention of nursing and midwifery staff was a long standing challenge for the trust and although some progress had been made there were still significant numbers of vacancies, 5% in senior nurses; 7% for nurses below band 7 and 5% in non-clinical staff.

Medical staffing

The recruitment of suitable and sufficient numbers of medical staff was also a managerial challenge at the time of our inspection there remained a 9% medical staff vacancy rate across the trust with 12% vacancy rate within consultants; 11% in other medical grades. We found that medical rotas were not well managed and governed. There was a reactive approach to completing rotas often at the last minute and a lack of oversight by senior staff.

There were ongoing concerns regarding the trusts approach and ability to recruit and retain medical staff.

Mortality and morbidity

The 12 month HSMR to October 2015 was 101.7 (as expected) and was on a downward trajectory reaching 95.2 to November 2015. However mortality due to pneumonia remained high with the report commissioned from Dr Foster in March 2016 showing the HSMR for 12 months to November 2015 as 122.6 and the SHMI for 12 months to June 2015 as 116.8.

Summary of findings

There was a lack of consistency to the application and evaluation of the trusts mortality and morbidity review. This meant there may have been missed opportunities for learning and improvement in some services where the process was not appropriately applied of monitored.

Incident reporting

At the time of the inspection he trust was ranked 87 of 137 similar sized organisations for the reporting of incidents The senior team acknowledged the need to increase the reporting of incidents including near misses so that potential risks could be mitigated and opportunities for learning and improvement applied.

There was a lack of risk awareness across the trust and new incident reporting systems within the policy were not fully embedded or understood.

There had been two Never Events reported in the last 12 months both related to medicines management but our review demonstrated that learning had been shared following investigation.

Environment and equipment

The management and replacement of equipment was better managed than at our previous inspection in November 2014 although there remained some areas of concern. In maternity one of the rooms used as a theatre was found not to be fit for purpose and has since been removed from use. Additionally the rehabilitation ward at Ormskirk was unsuitable for the safe and appropriate observation of patients this ward has since moved to an alternative more suitable location.

There were also concerns around the use of the theatre recovery area as an escalation area. This did not meet the needs of the patients and was a potential safety risk. Since our inspection, the trust has ceased this practice.

Mandatory Training

Mandatory training did not meet the trusts targets in 13 of 14 key areas. There was little improvement on the situation as it was in February 2015. The trust target for mandatory training was 90% but in many areas across all disciplines uptake was as low as 30% in some topic areas. In January 2016 Fire training uptake was 67% against a target of 90%; Basic resuscitation training uptake was 76% against a target of 90%; Infection control training uptake was 76% against a 100% target.

Patient Outcomes

There were concerns regarding the assessment and timely care to patients within the emergency department and the monitoring, escalation and treatment for patients whose condition deteriorated whilst they were in the trust in line with the introduction of an electronic EWS. We found examples in the surgical services were nursing staff had not completed the patient observations as per the policy and also had not escalated deteriorating patients to the medical team in a timely way. We raised this with the trust and these incidents were investigated. We were informed that there were some concerns regarding the electronic systems reliability and this was being investigated further.

Safeguarding

Safeguarding had been identified by the trust as an area requiring improvement but actions were on hold pending the results of a second service review. A new appointment to the leadership of the safeguarding service had been made but it was recent and too early to determine the impact on practice. Safeguarding training uptake was good across all disciplines except for administrative staff where it was reported as 0% in the urgent care service.

Fit and Proper Persons Regulation (FPPR)

The trust included the FPPR within the trusts recruitment and selection policy and the procedure was initiated in March 2015. The procedure met the requirements with the exception of the reviews for non-executive directors.

The interim executive's files were being held centrally by NHS Improvement at the time of the inspection as they held the responsibility for recruitment. However of the seven files of executive and non-executive appointments since November 2014 that were available for review, none contained all the information mandated within the trust policy.

It was evident from our review of records and incidents that although the trust was aware of its obligations in terms of the fit and proper person regulation, a robust process had not been robustly or consistently applied.

Duty of Candour

Summary of findings

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Duty of candour was not fully reflected in the trusts DOC guidance, policies were not cross referenced and the description of incidents that require DOC consideration did not include those incidents where moderate/severe harm was identified within a complaint and so were not consistently applied. Assurance processes were not robust and failed to identify all cases where the regulation must be applied due to a lack of a mandatory field within the electronic incident management system in regards to DOC. Staff knowledge and understanding of the DOC regulations was understood at department level however there were limited examples of the Doc being robustly applied.

Workplace Race Equality Standards

The trust was not compliant with Public Sector Equality Duty, which requires objectives to be reviewed annually and published every four years which has not happened and the cycle for 2016-17 was not under way. The contractual requirement for trusts to publish their results for the Workforce Race Equality Standard had not been met as neither had been produced nor published.

The BME consultant focus group recognised improvements since the interim board appointments had been made but still reported perceived discriminatory behaviour towards senior consultants specifically relating to inappropriate practices during recruitment processes and inappropriate use of MHPS and disciplinary processes.

The trust had instigated an independent investigation into these concerns following the previous inspection; however, a number of senior consultants considered opportunities were missed in terms of the scope of the review.

In addition, clinicians felt there was a lack of engagement in terms of their inclusion in service planning and future provision. There was no current clinical strategy and the review of the 2012-15 clinical strategy had not yet commenced.

They had subsequently made the interim Chief Executive and Chair aware of their concerns at an MSC meeting in October 2015. Since then, the Chair of that group had been given assurances that MHPS procedures would be better supervised and used appropriately.

However, a number of consultants continued to feel that further changes were required as they felt that there was very limited engagement and opportunities for inclusion.

However;

We saw significant improvements across all aspects of patient care and treatment at the North West Regional Spinal Injuries Unit that was rated as inadequate for safety at the last inspection. It is now rated as Good with some aspects of outstanding care practice.

We also saw improvement within the maternity service which was also rated as inadequate in the safety and well led domains at the last inspection. This rating has improved to requires improvement in both domains.

The new DON was having a positive impact in relation to the nursing agenda and nursing staff engagement.

We also found a lack of pace to the implementation of required improvements and a number of the improvements required at our last inspection were still to be implemented.

We saw several areas of outstanding practice including:

- The NWRSIC service had developed improvement in information for healthcare professionals. For example, following assessment, the outreach team had produced a document with written advice and instructions. This document had been developed by the NWRSIC by taking into account standards and protocols for SCI management practised nationally. This document has also been developed in co-operation and discussion with the outreach team at the Midlands Spinal Injuries Centre at Oswestry.
- The centre has been pivotal in providing training to other Spinal and Rehabilitation Centre's for the development of intrathecal baclofen pump services.
- The additional capacity the outreach service has brought to the centre had enabled patients referred to the centre from major trauma centres to be admitted faster. The length of referral to admission is now

Summary of findings

reducing ensuring patients are able to commence their rehabilitation sooner. However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Assess, monitor and act on the serious concerns raised regarding both the emergency department and surgical services. Particularly around EWS and sepsis management.
- Ensure that the governance mechanisms are robust enough to ensure the Board has clear oversight of all risks within the organisation.
- Ensure that all executive and non-executive appointees since November 2014 have been reviewed and documentation is held in line with the trusts policy for recruitment and selection in regards to the Fit and Proper person regulation.
- Improve the management of risk including the embedding of the revised processes for serious incident reviews including the use of RCA by trained staff and meet the timescales of their policy for Board oversight.
- Improve the adherence to the use of and escalation resulting from the use of the Early Warning Score electronic system.
- Improve the rigor of the Duty of Candour application.
- Improve the consistency and learning from mortality review processes.
- Ensure that they address all the actions detailed within the location reports.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Southport and Ormskirk Hospital NHS Trust

Southport and Ormskirk NHS Trust has two hospitals and a walk in centre and provides community services to a local population of 258,000 people across Southport, Formby, Sefton and West Lancashire. The health of people in Sefton is mainly worse compared with the England average.

The trust is an integrated care organisation (ICO), delivering care in hospital and the community and employs approximately 3,242staff, 270 Medical, 1,052 Nursing and 1920 other disciplines.

Acute care is provided at Southport and Formby District General Hospital and Ormskirk District General Hospital and had 23,084 admissions between September 2014 and August 2015. There are 497 beds, 455 General and acute, 27 Maternity and 15 Critical care.

The trust has a revenue of £188m and Full Costs of £189m giving them a Surplus (deficit) of (£896,000).

We inspected the trust as a focussed follow up to the inspection in November 2014 where the trust was found to require improvement. We visited between 12 and 15 April 2016. We visited Southport and Formby District General Hospital; Ormskirk District General Hospital; The Skelmersdale walk in Centre and community services for adults and community sexual health services for children.

The provision of local community services was the subject of a procurement process, for which the first stage was a pre-qualification questionnaire (PQQ) used as a means of shortlisting the potential bidders. At the time of our inspection the trust had been unsuccessful in clearing the PQQ for West Lancashire community services, but had been for Southport and Formby.

Our inspection team

Our inspection team was led by:

Chair: Professor Iqbal Singh;

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included two Inspection Managers, 12 CQC inspectors, a CQC Pharmacy Inspector and a variety of specialists including Executive Director of Nursing & Quality; Senior Quality and Risk Manager; Head of Safeguarding; Race and equality expert; A&E Consultant; A&E Staff Nurse; Medical Consultant; Ward Manager in Medicine; Surgical Consultant; Theatre Manager; Critical Care Consultant; Advanced Nurse Practitioner; Paediatric Consultant; Paediatric Nurse; Outpatients Nurse; Retired Consultant in Palliative Care; EOLC Nurse - Director of Nursing; Consultant in Trauma & Orthopaedics; Consultant Nurse Orthopaedics; Occupational Therapist; Health Visitor.

CQC Deputy Chief Inspector, Hospitals North also joined the inspection for a day. We were also supported by three Experts by Experience.

How we carried out this inspection

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

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

The inspection team inspected the following eight core services at the hospitals of Southport and Ormskirk Hospitals NHS Trust:

- Accident and emergency

Summary of findings

- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

We also inspected the Community Services for Adults and the Community Sexual Health Services for children.

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

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Southport and Ormskirk Hospitals NHS Trust.

What people who use the trust's services say

The trust performed amongst the top 20% for seven questions, the bottom 20% for 12 questions and the middle 60% for the 15 questions in the Cancer Patient Experience Survey 2013/14.

In the CQC inpatient survey 2014 the trust performed about the same as other trusts.

The Friends and Family Test performance showed an overall trend of improvement between July 2014 and January 2016.

The trust received 436 complaints in 2014/15 which is the highest number reported over the last 5 years.

There was mixed performance in the 2015 PLACE audit.

Facts and data about this trust

The population is of high levels of older people and young families. Deprivation is slightly lower than average, however about 20% (9,340) children live in poverty. Life expectancy for both men and women is lower than the England average. The health of people in West Lancashire is mixed compared to the England average. Deprivation is about the same as the average and about 16% (3,250) children live in poverty. Life expectancy for both men and women is lower than the England average.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	Requires improvement 

Summary

The trust was rated as requires improvement for safety because;

- There were significant concerns regarding the assessment and timely care to patients within the emergency department, patients waited excessive amounts of time to be seen and assessed, some patients remained in the department under the supervision of ambulance staff for periods of up to 11 hours because of a lack of capacity in the department. There continued to be very poor performance regarding patients being seen within four hours in the A&E department with extensive waits for patients who remained in the supervision of the ambulance service for up to 11 hours. Percentage compliance rate against the 4 hour A&E wait differed between the two hospital sites with Ormskirk delivering at high percentages but the Southport site was performing at much lower levels. Over January 2016 Southport performed between 51% and 75% against the Ormskirk site performance between 99% and 100%. This meant that the trust wide performance was between 80% and 89% masking the very poor performance at the Southport site. Year-to-date performance at February 2016 was 92.9%, driven primarily by performance of 60.4% at Southport. February 2016 performance was 84.5% (53.7% in Southport). The department failed to meet this target between February 2015 and April 2016.
- Safety did not have a sufficient priority across surgical services. Systems, processes and accepted operating procedures were not always reliable or appropriate to keep people from avoidable risks and harm.. We saw examples of practices which demonstrated that staff did not recognise concerns, incidents and near misses and the consequent risks presented to patients.
- There was a repeated failure to comply with trust policy for the checking of controlled drugs. It was accepted practice for patients to be placed on oxygen without it being prescribed or without a target saturation level being identified.
- Ward entrance doors were left unlocked and unattended even though there were confused, hypermobile patients on the ward who were at risk of absconding and getting lost.

Summary of findings

- We found that staff did not always assess monitor or manage risks to people who use the services and opportunities to prevent or minimise harm were missed. Medically deteriorating patients were not always identified promptly and when they were identified through the electronic EWS it was reported that out of hours there could be a delay before medical assessment was undertaken. We also saw evidence of a delay in the response time of the critical care outreach team to a patient with a high early warning score. We found that nutritional risk assessments were not always completed for patients who were clearly vulnerable. In addition fluid balance charts were not consistently kept updated on all wards.
- Duty of candour was not fully reflected in guidance and so not consistently applied. Assurance processes were not robust and failed to identify all cases where the regulation must be applied.
- Safeguarding had been identified by the trust as an area requiring improvement but actions were on hold pending the results of a second review although leadership of the safeguarding service had improved. In the interim the trust had limited assurances that issues of abuse and neglect were escalated and managed appropriately. Safeguarding training uptake was good across all disciplines except for administrative staff where it was reported as 0% in the urgent care service.
- There had been two Never Events reported in the last 12 months.
- The trust was ranked 87 of 137 similar sized organisations for reporting of incidents at the time of the inspection. They acknowledged the need to increase the reporting of incidents including near misses so that potential risks could also be monitored. There was a lack of risk awareness across the trust and the new systems within the policy were not embedded.
- Recruitment and retention was a long standing challenge for the trust and although they had made progress there remained a 9% staff vacancy rate across the trust with 12% vacancy rate within consultants; 11% in other medical grades; 5% in senior nurses; 7% across nurses below band 7 and 5% in non-clinical staff.
- There was a need for better governance around the medical staff rotas and there was a reactive nature of rota filling. There were concerns around retention and succession planning. Staffing on one surgical ward was observed to have impacted patients as there were insufficient numbers of staff for the number of patients that required significant support to eat their

meals with patients waiting too long for their lunch. We witnessed a patient about to fall out of bed. Nursing staff voiced concerns about staffing levels and were visibly distressed by the issue.

- The Trust had identified in October 2015 that there was no agreed process for promptly alerting medical staff to MHRA alerts and this remained a concern.
- Mandatory training did not meet the trusts targets in 13 of 14 key areas. There was little improvement on the situation as it was in February 2015. The trust target for mandatory training was 90% but in many areas across all disciplines uptake was as low as 30% in some topic areas.
- In maternity one of the rooms used as a theatre was found not to be fit for purpose and has since been removed from use.
- The bleep system used to call for medical assistance by the wards was old and unreliable with reports of bleeps not working in certain areas of the trust. We were told that a new system had been procured but had not implemented. This concern was raised at our last inspection.
- Access to the machines for determining patient blood gas levels was unreliable as we were informed that there were two but access to the one in the intensive care unit was limited and the one in the emergency department was regularly out of order.
- Medicines management had improved since the last inspection although there were still a few areas of concern, for example there was no agreed process for promptly alerting medical staff to MHRA alerts.
- The management and replacement of equipment was better managed although there remained some areas of concern. This included older equipment which was awaiting replacement due to financial constraints.

Assessing and responding to patient risk

- We identified a number of cases of sub-optimal care in accident and emergency with particular reference to the management of patients with sepsis. There was one particular incident relating to the management of sepsis that led to a potentially avoidable death. This was immediately raised with the executive team and asked for urgent assurance in respect of the management and mitigation of the identified risks.
- The trust responded positively with an action plan that included an immediate increase in both medical and nurse staffing to enable prompt triage and timely intervention. The plan also included the introduction of additional supportive roles in respect of patient safety. We were assured on leaving site that the immediate risks had been mitigated and that the

executive team now had a clear oversight of the risks and were reviewing them daily. The emergency department was revisited at the unannounced inspection and some improvements were noted including senior oversight and improved staffing.

- The bleep system used to call for medical assistance by the wards was old and unreliable with reports of bleeps not working in certain areas of the trust. We were told that a new system had been procured but had not yet been implemented. This issue was raised at the last inspection and it was disappointing to note that it had still not been addressed as there was a risk that medical staff could not be contacted in a timely way and patient review cold be affected.
- The trust used an electronic system to record Early Warning Scores (EWS). The system was used to alert staff if a patient's condition was deteriorating using a set of observations including temperature, pain score and respiratory rate. Observations were increased if there were signs of a patient deteriorating. However, we found a number of instances where patients whose condition was deteriorating were not escalated in a timely and appropriate way.
- We found a number of incidents coupled with information from external sources regarding the inconsistent use of the incident reporting system, regarding the timely reporting of patients whose condition was deteriorating; this had resulted in a lack of timely medical review and was detrimental to the patients' welfare in a number of cases.
- There had been a significant reduction in pressure ulcers at grade 3 and 4.
- The rate of patient falls was amongst the lowest in the north west of England.

Duty of Candour

- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify the recipients of care (or other relevant persons) of 'certain notifiable safety incidents' as soon as reasonably practical and provide reasonable support to that person.
- There was a policy in place that described the process for the management of incidents that require discharge of the Duty of Candour (DOC) regulation but it did not cross reference the complaints policy. The description of incidents that require DOC consideration did not reflect the full requirements of the regulation in that it did not include those incidents where moderate/severe harm was identified within a complaint.

- The policy states that assurance of DOC completion can be gained from the electronic incident management system but we found assurance of compliance with the policy was limited due to the lack of a mandatory field within the electronic incident management system in regards to DOC.
- Staff knowledge and understanding of the DOC regulations was understood at department level. However there were limited examples of the Doc being robustly applied.

Safeguarding

- There was a second safeguarding review underway at the trust but it was noted that no actions had been taken in respect of the issues highlighted in the previous safeguarding review.
- Some staff felt that safeguarding concerns had not been recognised or supported at an appropriate level under previous executive leadership.
- Safeguarding training uptake was good across all disciplines except for administrative staff where it was reported as 0% in the urgent care service.
- The trust safeguarding committee reported to the Quality Group which fed in to the Board. However senior attendance at this meeting was inconsistent.
- The safeguarding children's policy was in need of updating with relevant national guidance but this had been put on hold because of the second review.
- Attendance at local Safeguarding Children's Boards was poor with only one attendance in the last 12 months for Lancashire LSCB and three at Sefton LSCB.
- There was evidence of some support for frontline staff in urgent care and there was a plan to train more supervisors. There was evidence that the safeguarding children's training and supervision was of a good standard according to evaluation forms.
- Safeguarding within midwifery was improving, compliance with supervision was improving and there were strong links with the local authority and neonatal safeguarding. However there was a need for the domestic abuse policy and training to be reviewed.
- Concerns were raised regarding the number of cases recorded on the Child Sexual Exploitation list but it was noted that the list was not reviewed and so no cases were ever removed. However it was noted that looked after children were not flagged on the accident and emergency system.

- There was a named doctor for safeguarding but the role did not have a clear link to the executive safeguarding lead. This had been delegated to a less senior nursing role. The post holder had not been involved in any of the review work which had been undertaken or was underway.

However,

- The named doctor for safeguarding led supervision for senior medics using case studies to support their learning.
- There were good links with a local children's acute hospital which provided supervision. There were two CAMHS services but there were good processes with a local children's acute hospital which mitigated the risks.

Incidents

- The policy on reporting and managing risk met the requirements of the NHSLA Risk Management Standards.
- Trust incident reports were completed on an online electronic incident form .Incidents severity was determined using the Incident Risk Matrix, Severity and Likelihood scoring tool matrix.
- The incident grading system was included from the Trust Incident Reporting Policy, which was under review due to the recent changes in the Serious Incident processes as a result of a new national framework.
- The senior team was acknowledged that there was a lack of risk awareness and that the systems in place to manage and mitigate risks associated with incident management were not fully embedded and understood within the trust.
- The trust was ranked 87 of 137 similar sized organisations for reporting of incidents at the time of the inspection. All serious incidents were reported to the Board on a monthly basis.
- Serious incidents were investigated using Root Cause Analysis (RCA) and training was on-going however, the investigations we reviewed did not demonstrate full and robust components of RCA in practice. We found some RCA's to be of poor quality and limited application of learning resulting from investigations.
- We found the serious incident process was not conducted in line with the timeframes stipulated in the policy for Board oversight. We also found here was limited board oversight and evaluation of learning and improvement from incidents and subsequent investigations.
- There had been two Never events reported by the trust in the last year, both related to medicines management. However, evidence of the implementation of improvements and learning to prevent recurrence was limited at the time of our inspection.

Medical Staffing

Summary of findings

- The trust had 13 consultant vacancies of a total workforce of 108 (12%). They had made steady progress in recruiting consultants making 14 appointments since the autumn of 2015.
- However there were still a number of vacancies in medicine and the A&E department that were adding additional pressures on already challenged services. There were 22 vacancies in other medical grades from a workforce of 203 (11%).
- The trust utilised appropriately qualified and experienced locums to cover areas of shortfall.
- Medical staffing was discussed in the board meetings and there was evidence of discussions regarding progress with recruitment and the use of locums and recruitment.

Nurse and Midwifery Staffing

- There were two band 8 and above nurse vacancies of a total of 39 staff (5%).
- There were 116 vacancies in band 7 and below nurses of a workforce of 1701 (7%).
- There was an almost 5% vacancy rate in the non-clinical workforce and overall a 9% vacancy rate.
- The trust board was kept well informed of the status of staffing through a monthly report which included the use of bank and agency nurses and the recruitment processes. Non-executive directors commented that they felt assured about progress and future plans whilst recognising the challenges.

Medicines Management

- Since our last inspection, medication storage on Critical Care had improved and all medicines were safely stored.
- Medicines optimisation was identified as a priority for the board.
- The Trust had rolled out electronic discharge across the hospital to ensure the secure and promptly transfer of patient information. However, accident and emergency and on occasions the observation ward still used paper discharge records.
- Following a recent medication incident, a provision of clinical pharmacist support to A&E was being piloted. Nursing staff told us they felt that the active involvement of a pharmacist was improving medicines safety. A business case for the integration of pharmacy into the accident and emergency and observation ward had been prepared for Board approval. However, this had not been confirmed at the time of our inspection.

Summary of findings

- The Trust had taken positive action to improve the reporting of adverse drug reactions, after identifying that they were one for the lowest reporters in the region, as a result adverse drug reaction reporting rates have quadrupled.
- The pharmacy team was actively involved in providing training to junior medical staff (F1 and F2) and medical students in aspects of safe prescribing. Medicines' training was not mandatory at the Trust but, nurse training in medicines optimisation was delivered to new appointees and for those staff who had encountered problems with medicines.
- The Trust had identified in October 2015 that there was no agreed process for promptly alerting medical staff to MHRA alerts; this remained on the agenda in January 2016.

Mandatory training

- Mandatory training did not meet the trusts targets in 13 of 14 key areas. There was little improvement on the situation as it was in February 2015.
- In January 2016 Fire training uptake was 67% against a target of 90%; Basic resuscitation training uptake was 76% against a target of 90%; Infection control training uptake was 76% against a 100% target.

Environment and Equipment

- At the last inspection there was a lack of a scheduled equipment replacement scheme across the trust and there was no assurance that equipment was fit for purpose and safe for use.
- The trust now had a system and process in place and had an asset register which meant they had oversight of the equipment, servicing and replacement requirements.
- In theatres, the emergency department and outpatients there remained concern regarding the equipment that was in use due to the age of some equipment.
- Room eight on labour ward was used as a second theatre and was not fit for purpose. There was no diathermy, no ensuite facilities in the room, incorrect flooring, no drug cupboard, staff had to scrub and walk across the corridor and there was insufficient space to manoeuvre and manage patients safely. Since our inspection this has now been taken out of use.
- There was a resuscitaire inappropriately stored in the midwives office/handover room. This has since been removed.
- The lift used to transfer in a maternity emergency could be delayed as it was used by others.

Summary of findings

- Junior doctors explained that there was a lack of access to machines to determine patient blood gas levels. These tests are required when patients are experiencing difficulty breathing and so reliable access is important to patient care. This was reported to the trust for action.
- Staff of the facilities department at SFDGH worked in an environment that was not conducive with safe working practices. The fire evacuation doors were on the one corridor and the egress through one door was blocked by stored bins outside. There were no heat detectors in the workshop areas. Ventilation was poor. The emergency generator was also in the same building. Hygiene facilities were limited especially for equipment prior to return to the hospital site. This was raised with the trust and alternative arrangements were to be made.

Are services at this trust effective?

Requires improvement

The trust was rated as requires improvement for effectiveness because;

- Although guidance and clinical pathways reflected national guidance they were not always followed by staff.
- Some surgical patients were fasted for longer than required without reference to their individual requirements.
- There was a need to improve performance in some of the national audit programmes including Myocardial Ischaemia National Audit Project (MINAP), the national emergency laparotomy audit and the national hip audit.
- There was a lack of evidence of the embedding of knowledge and practice across the trust regarding the application of MCA and DoLS although this issue was logged on the corporate risk register. There were concerns that there was under reporting of DoLS that the trust was addressing by providing additional training however the uptake was low at 59% with a trajectory to meet compliance by November 2016.
- Junior medical staff told us the administrative support for the maintenance of patient records and transfer of patient investigation requests was inconsistent and vacant on some wards which meant the junior doctors were having to deliver requests by hand which took them away from the patients.
- There was a lack of multidisciplinary working or an IT solution to this basic problem.
- Staff appraisals and personal development was inconsistent with reports of training sessions for junior medics regularly cancelled at short notice. Junior medical staff were also concerned that they were not provided with t formal introductions to the clinical leads.

Summary of findings

However;

- Latest HSMR and SHMI were within expected ranges.
- The trust had developed a patient safety collaborative to increase quality and safety for patients in a number of areas.
- The trust was in the top decile for performance in cancer care.
- The trust was in the top quintile for Referral to Treatment Times.
- Attributable cases of C.difficile were under trajectory for the second year.
- There had been a significant reduction in pressure ulcers at grade 3 and 4.
- The rate of patient falls was amongst the lowest in the north west of England.

Evidence based care and treatment

- Guidance and clinical pathways reflected current national standards and guidance in most areas although there was room for improvement in the children's services.
- Although national and local guidelines and care pathways were in place to support staff providing care in the emergency department, we found use of the pathway for managing sepsis was limited and some elements of sepsis care were worse than the regional average.
- Patient pathways were also not always followed in outpatients and surgical services.
- We found that some surgical patients were being fasted for longer periods than indicated by national guidance.
- Performance in national audits required improvement in areas including emergency laparotomy, bowel and lung cancer and hip fractures

Patient outcomes

- The latest SHMI data for the year to June 2015 was 105.6 (as expected) which was an improvement over the previous rate of 107 for the year to December 2014. A score of over 100 means more adverse (worse) outcomes than expected and a score of less than 100 means less adverse (better) outcomes than expected.
- The 12 month HSMR to October 2015 was 101.7 (as expected) and was on a downward trajectory reaching 95.2 to November 2015. However mortality due to pneumonia remained high with the report commissioned from Dr Foster in March 2016 showing the SMR for 12 months to November 2015 as 122.6and the SHMI for 12 months to June 2015 as 116.8.

Summary of findings

- The emergency department monitored re-attendance rates for patients which were consistently higher (worse than) than the national average.
- The trust participated in all the relevant national clinical audits.
- In the Myocardial Ischaemia National Audit Project (MINAP) the trust need to improve the number of patients who are admitted to a cardiac unit as only 26.2% were which was worse than the England average of 52.6%.
- In the Sentinel Stroke National Audit Programme (SSNAP) from April 2014 to March 2015 the trust rating improved to a grade 'C' from a 'D'. The trust had taken action to improve the stroke service which now had dedicated protected stroke beds. The stroke unit had recently moved to a smaller 22 bedded unit and stroke assessors had a 24 hour, seven day per week working pattern to ensure that patients admitted through accident and emergency were seen.
- Stroke performance was being monitored and reviewed through a stroke task and finish group however trust wide access and flow issues were affecting the use of the unit. The stroke-specific SMR had decreased to within expected range and was 92.8 in the calendar year to November 2015.
- Outcomes for people who use the surgical services were below expectations compared with similar services. There were readmission rates of 165 for elective surgery, which was significantly higher than the England average of 100. In the national emergency laparotomy audit (NELA) 2015 which uses 11 indicators to assess the care and treatment of patients requiring emergency laparotomy the trust achieved only three.
- The trust performance in the 2015 national audits for lung and bowel cancer was mixed. Performance in the national hip audit, which measures eight indicators related to the care and treatment of patients admitted to hospital with a fracture of their hip, was worse than the England average in five of the eight indicators.
- The trust had developed a patient safety collaborative to increase quality and safety for patients in a number of areas. The collaboratives aim was to empower local patients and healthcare staff to work together to identify safety priorities and develop solutions. For example, the trust had developed a collaborative to reduce the number of pressure ulcers being seen in both acute and community settings. Since the start of the collaborative in July 2015 the trust reports there had been a 25.7% reduction in reported pressure ulcers since the baseline data was collated. .
- The trust was in the top decile for performance in cancer care.

- Attributable cases of C.difficile were under trajectory for the second year.

Multidisciplinary working

- There was evidence of good multidisciplinary working across the trust.
- This was particularly noticeable within the stroke and spinal injury services where high levels of managerial support were reported.
- However the pharmacy technicians did not share the same positive experiences and expressed their concern regarding their inability to spend time on the wards and departments.
- Staff reported an improved culture with more cohesive strategies and collaborative working to improve multidisciplinary working. Staff felt that following a period of stagnation, business cases that would improve and develop services were now being considered.
- Junior medical staff told us the administrative support for the maintenance of patient records and transfer of patient investigation requests was inconsistent and on some wards absent which meant the junior doctors were having to deliver requests by hand thus affecting the time they spent with patients.
- We found no evidence of multidisciplinary working or a collaborative IT solution to resolve this basic problem.
- Staff felt that improvements in the IT service would assist in the improvement of multidisciplinary working by allowing improved communication and information sharing.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- There was a lack of evidence of the embedding of knowledge and practice across the trust regarding the application of MCA and DoLS .This had been identified as an organisational risk and logged on the corporate risk register. The was under reporting of DoLS that the trust was addressing by providing additional training however the uptake was low at 59% with a trajectory to meet compliance by November 2016.
- Consent policies and procedures were in place and followed by staff.

Staff Appraisal and development

Summary of findings

- Staff appraisals and personal development plans were in place although staff told us many of the appraisals had been completed in the two weeks leading up to the inspection. We found that in some areas they were not up to date, for example in community where some were only at 50%.
- Staff expressed concern about the lack of development opportunities related to the staff shortages as they were unable to leave the departments to attend training.
- Junior nursing staff did not meet as a professional group and staff felt this may help them to share learning and knowledge.
- Junior doctors told us that training sessions were regularly cancelled particularly the speciality training scheduled for Fridays which rarely happened and F1 training where several had been cancelled and had been raised with the local trainer.

Are services at this trust caring?

Good

Summary

The trust was rated as good for caring because;

- Care was delivered by caring and compassionate staff who were open, friendly and helpful to patients.
- The trust performed amongst the top 20% for seven questions, the bottom 20% for 12 questions and the middle 60% for the 15 questions in the Cancer Patient Experience Survey 2013/14.
- In the CQC inpatient survey 2014 the trust performed about the same as other trusts.
- The Friends and Family Test performance showed an overall trend of improvement between July 2014 and January 2016.

However;

- The trust received 436 complaints in 2014/15 which is the highest number reported over the last 5 years.
- There was mixed performance in the 2015 PLACE audit.

Compassionate care

- Staff were seen to be caring in their interactions with patients with particular note in the Regional Spinal Injuries Unit and where we observed there was a strong, visible person-centred culture.
- Patients received compassionate care and their privacy and dignity were always maintained, patient's emotional, social and religious needs were embedded in their care and treatment.

Summary of findings

- Most patients and their families were positive about their interactions with staff. They told us that the staff were kind, polite and respectful, and they were happy with the care they received.
- We observed staff being open, friendly and helpful to patients and each other.

Understanding and involvement of patients and those close to them

- We observed staff providing emotional support to patients when they were distressed. This was particularly the case for patients who were confused and agitated.
- Clinical nurse specialists were available.
- Due to the nature of the care provided in critical care, patients could not always be directly involved in their care. Where possible the views and preferences of patients were taken into account and this was documented in their records. Relatives of patients told us staff had asked them about patient preferences and likes and dislikes.
- Patients said they had been involved in their care and were aware of the discharge plans in place.
- The majority of patients we spoke with said they had received good information about their condition and treatment.
- The patient Passport was utilised to support patients with limited communication to ensure their views and preferences were taken note of.

Emotional support

- Staff understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to patients.
- Staff provided emotional support to patients in a calm and respectful way.
- Staff could seek support from the palliative care team if a patient required end of life care. Staff were also able to provide overnight accommodation for relatives of patients.
- There were information leaflets readily available that provided patients and their relatives with information about chaplaincy services and bereavement or counselling services.

Are services at this trust responsive?

Requires improvement

We rated the trust as requires improvement for responsiveness because;

Summary of findings

- The emergency department was still experiencing significant flow issues with significant delays for patients occurring regularly. Black breaches had significantly increased between November 2015 and January 2016 reaching over 300 in January 2016.
- Following our previous inspection where we found the emergency department was below (better than) the England average for number of patients waiting between four and 12 hours for admission following a decision to admit being made, we found that the department was now above (worse than) the England average. The number of patients waiting between four and 12 hours from the point of decision to admit and actual admission between February 2015 and April 2016 was an average of 195 patients each month waited between four and 12 hours.
- Following findings that the emergency department was not meeting the Department of Health target to admit, treat or discharge 95% of patients within four hours during the last inspection, we found that the target was still not being met during this inspection. Percentage compliance rate against the 4 hour A&E wait differed between the two hospital sites with Ormskirk delivering at high percentages but the Southport site was performing at much lower levels. Over January 2016 Southport performed between 51% and 75% against the Ormskirk site performance between 99% and 100%. This meant that the trust wide performance was between 80% and 89% masking the very poor performance at the Southport site. Year-to-date performance at February 2016 was 92.9%, driven primarily by performance of 60.4% at Southport. February 2016 performance was 84.5% (53.7% in Southport).
- Where the total average time spent in the emergency department was found to be below (better than) the England average, we found that it was consistently higher (worse) than the England average following this inspection. The average time taken to provide treatment was also consistently above (worse than) the Department of Health target of 60 minutes.
- Bed occupancy, length of stay, and delayed transfers of care had an impact on the flow of patients throughout the hospital due to the demand for medical services. Bed occupancy at the hospital in January 2016 had increased from 90.8% to 94.3% in March 2016.
- The numbers of patients outlying on surgical wards from medicine and trauma and orthopaedics was impacting on the

surgical service performance. The percentage of cancelled operations was above the national average of 1% but there were only two cases which had not received treatment within 28 days of the cancellation.
- From February 2015 to January 2016, 7499 (25%) of admitted patients moved once during their admission. Patients were often moved at night, in January 2016, 170 patients were moved after 10pm. This was a reduction on the previous five months where the patient moves had exceeded 200. Moves for non-clinical reasons are not good experiences for patients.
- Referral to treatment targets were mainly being met although the trust was slightly below the target for patients referred from NHS screening which was below the target of 85% at 73%; treatment within 18 weeks of referral was slightly below the target of 90% at 83.4%.
- There was a policy for handling complaints but the system was under intense pressure and it appeared there was a lack of capacity to deliver against the process described in the policy. There was not a clear focus on learning from complaints although the trust was aware of this and was reviewing its processes.
- Provision of support for patients with complex needs was in place but there was room for improvement in signage and the effective identification of patients with complex needs.

However;

- Bed meetings occurred regularly throughout the day during the week days to review and plan bed capacity and respond to acute bed availability pressures. We found that it was attended by senior staff and found the system to be effective and comprehensive.
- Elderly patient care (frailty care) accounted for approximately 25% of the work in the emergency department. In response to this, a specialist 'therapy' team had been set up to better manage frailty care.
- There were robust policies and processes to ensure people with LD are identified and reasonable adjustments made for both the patient and their care if appropriate.

Service planning and delivery to meet the needs of local people

- Care was delivered across two hospital sites with adult emergency services at Southport and children's at Ormskirk. Maternity services were only at Ormskirk.
- The needs of the local population were changing. The emergency department described the majority of patients as

attending with minor problems in the past but this had changed, with a greater proportion of patients now requiring more complex care. However the department had not been designed to meet these changing demands.

- Elderly patient care (frailty care) accounted for approximately 25% of the admissions in the emergency department. In response to this, a specialist 'therapy' team had been set up to better manage frail elderly patients.
- The trust was meeting the 31 day and 2 week cancer wait targets; two of the three 62 day cancer targets were being met but not for patients referred from NHS screening which was below the target of 85% at 73% at the time of the inspection.
- Three of the five waiting time targets for non-urgent consultant led treatment were being met but the percentage of admitted patients starting treatment within 18 weeks of referral was slightly below the target of 90% at 83.4% and the A&E 4 hour target was at 91.4% against a target of 95%.
- Following the implementation of an electronic chemotherapy clinical system, the Trust was planning to implement electronic scheduling to help clinicians manage resources for patients receiving chemotherapy, ensuring that appointment dates aligned with prescribed cycles of treatment.

Meeting people's individual needs

- The trust had developed a Frail Elderly Short Stay Unit (FESSU) to provide elderly patients with a comprehensive geriatric assessment with a multi-disciplinary approach to reduce the length of stay for the older population. We visited the ward and found that patients were assessed and a multi-disciplinary approach to care was evident.
- Telemedicine (the remote diagnosis and treatment of patients by means of telecommunications technology) was used for stroke patients outside of normal working hours. This meant that patients could be given the most appropriate treatment quickly and without the need for transfer to another hospital.
- Bed meetings occurred regularly throughout the day during the week days to review and plan bed capacity and respond to acute bed availability pressures. We attended a morning bed meeting and found that it was attended by senior staff and found the system to be effective and comprehensive.
- From February 2015 to January 2016, 7499 (25%) of admitted patients moved once during their admission. Only 5% of patients moved twice and only 1% of patients moved three times or more. However a high number of patients were being moved after 10pm. In January 2016, 170 patients were moved after 10pm. This was a reduction on the previous five months

where the patient moves had exceeded 200. Eight patients on the frail elderly unit had been moved after 10pm, 16 patients on 7a, 11 patients on 11b, and 10 patients on the stroke unit, had been moved after 10pm. Bed moves after 10pm should be kept to a minimum to ensure that patients get the rest they need whilst receiving care and treatment.

- The trust had a discharge lounge; however this was being used as a bedded area so was not in use at the time of inspection. Staff reported that this area was used often to provide extra bed spaces for patients and was part of the escalation plan during bed pressures.
- The trust uses a flagging alert system for patients who have a known Learning Disability. New patients that attend the Trust have a flag applied by the adults at risk team. This also enables the team to add information regarding any reasonable adjustments that patients may need to support visits/ admissions to the hospital i.e. use of own carers/appointment times.
- The trust does not employ an LD specialist nurse. The LD liaison service was part of the Adults at Risk Team. Acute admissions of patients with learning difficulties were notified to the team by nursing staff, the sharing of a daily additional needs patient list, and external providers ringing the team if their clients were to be admitted.
- Elective admissions are notified to the team by the pre-op nursing team, external providers and the community LD team.
- The appropriate community LD teams were contacted to see if the patient was known to them allowing information sharing and joint working to support patients throughout their hospital journey. Access to and the use of health passports also assisted the assessment process.
- The use of a patient's own carers was supported throughout the patient journey. -.
- The Trust has signed up to Johns Campaign to welcome carers in to the hospital to support patients over the 24 hour period. For patients who are cared for by family/non-paid carer's overnight stays can be facilitated at the patient bedside. For patients who are attending for planned procedures strong partnership working and discussion with community LD teams support further adjustments needed on an individual basis. Specific out-patient times and extended appointments are also provided.

Dementia

- The trust did not have an electronic dementia flagging system. They utilised a paper resource that was updated daily by the bed management team during the evening review of the wards. This was then shared with the adults at risk team who used the information to provide further support as required.
- The adults at risk liaison team supported vulnerable adults, but they did not have a specialist lead dementia nurse. The adults at risk team are notified about vulnerable adults via a designated phone line and a daily report from the bed management team. The adults at risk team are responsible for all patients who may be at risk.
- They had a frail elderly Consultant team who provided medical support across the organisation. The team worked from the frail elderly ward that was also supported by allied health professionals such as Occupational Therapy and Physiotherapy.
- The Orthopaedic ward had an identified bay where patients who were assessed as living with dementia could be provided with supportive interventions such as reminiscence therapy .The bay was staffed with a healthcare support worker at all times.
- Staff utilised hospital passports for all vulnerable adults. A reasonable adjustments checklist was embedded within the nursing documentation so that care could be provided in a personalised way.
- The trust had initiated signage improvement across both sites to ensure that it was dementia friendly. All wards and departments had day / night dementia friendly clocks.
- The trust had signed up to Johns campaign which encourages carers to support patients who are vulnerable and allows them access 24hrs a day to provide reassurance and care as appropriate.
- The trust had also trained volunteers to assist patients with eating and drinking called 'Come Dine With Me'.
- The trust did not audit care for patients living with dementia.

Access and flow

- The emergency department was still experiencing significant flow issues with significant delays for patients occurring regularly. Black breaches had significantly increased between November 2015 and January 2016 reaching over 300 in January 2016.
- Following findings that the emergency department was not meeting the Department of Health target to admit, treat or discharge 95% of patients within four hours during the last inspection, we found that the target was still not being met

during this inspection. Percentage compliance rate against the 4 hour A&E wait differed between the two hospital sites with Ormskirk delivering at high percentages but the Southport site was performing at much lower levels. Over January 2016 Southport performed between 51% and 75% against the Ormskirk site performance between 99% and 100%. This meant that the trust wide performance was between 80% and 89% masking the very poor performance at the Southport site. Year-to-date performance at February 2016 was 92.9%, driven primarily by performance of 60.4% at Southport. February 2016 performance was 84.5% (53.7% in Southport).

- Following our previous inspection where we found the emergency department was below (better than) the England average for number of patients waiting between four and 12 hours for admission following a decision to admit being made, we found that the department was now above (worse than) the England average. The number of patients waiting between four and 12 hours from the point of decision to admit and actual admission between February 2015 and April 2016 was an average of 195 patients each month waited between four and 12 hours.
- Where the total average time spent in the emergency department was found to be below (better than) the England average, we found that it was consistently higher (worse) than the England average following this inspection. The average time taken to provide treatment was also consistently above (worse than) the Department of Health target of 60 minutes.
- Bed occupancy, length of stay, and delayed transfers of care had an impact on the flow of patients throughout the hospital due to the demand for medical services. Bed occupancy at the hospital in January 2016 had increased from 90.8% to 94.3% in March 2016. Evidence shows that when bed occupancy rises above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Due to the bed occupancy rate across medical wards, a number of patients were placed on wards that did not necessarily specialise in the care they required (also known as outliers). The trust reported that there had been an increase in the number of outliers between January and March 2016. Data provided to us indicated that for the month of March 2016 there were 118 medical patients occupying surgical beds.

Learning from complaints and concerns

- There was a Policy for handling complaints but the system was under intense pressure and it appeared there was a lack of capacity to deliver against the process described in the policy.

Summary of findings

- The complaints review panel was under review as it had only had a monitoring format rather than focussing on learning from complaints and had no executive input.

Are services at this trust well-led?

Requires improvement

The trust was rated as requires improvement for being well-led because;

- Since August 2015 the three members of the executive team had been excluded from the trust following three separate whistleblowing complaints. No aspects of the whistleblowing complaints or investigation related to issues of patient care or safety.
- There were significant failings within the governance processes of the organisation including a lack of Board oversight of all risks, inconsistent use of the committee structures to provide assurance to the Board, changes to the pharmacy governance arrangements which would not clearly support the principles of the medicines safety alert 'Improving medication error incident reporting and learning, March 2014' with regard to identifying, developing and promoting best practice for medication safety.
- Despite two never events relating to medicines management there was no designated committee to lead on the review of medication errors throughout the Trust, and in the absence of a champion, a pilot initiative to collect data for the NHS Medicines Safety Thermometer had been discontinued.
- We heard from staff and their representatives that they had seen a shift in culture at executive level but they felt the pace of change was too slow.
- There was no evidence of a vision or strategy regarding workforce race equality.
- The trust was not compliant with Public Sector Equality Duty, which requires objectives to be reviewed annually and published every four years which has not happened and the cycle for 2016-17 was not under way. The contractual requirement for trusts to publish their results for the Workforce Race Equality Standard had neither been produced nor published.
- There was no evidence in Trust board minutes since September 2015 of strategic discussions at board re: race equality. Whilst equality was discussed briefly in the context of the HR quarterly report that included reference to the staff survey, no future direction was discussed or set.
- The BME consultant focus group recognised improvements since the interim board appointments had been made but still reported perceived discriminatory behaviour towards senior

consultants specifically relating to inappropriate practices during recruitment processes and inappropriate use of MHPS and disciplinary processes. The trust had instigated an independent investigation following the previous inspection, however, a number of senior consultants considered opportunities were missed in terms of the scope of the review.
- Consultants had since made the interim Chief Executive and Chair aware of their concerns at an MSC meeting in October 2015. Since then, the Chair of that group had been given assurances that MHPS procedures would be used appropriately.
- The trust did not meet the requirements of the Fit and Proper Person Regulation.
- Staff engagement had improved but there were still sections of the workforce who did feel to be completely engaged in operational or strategic changes that were happening within the trust.

However;

- In the meantime there have been interim directors supporting the executive team.
- The Trust Development Agency (now NHS Improvement) has been supporting the trust through this difficult period.
- The Director of Nursing and Quality was new to the trust from February 2015 but was having a positive impact in relation to the nursing agenda and nursing staff engagement.
- There had been a recent appointment of a BME non-executive director with extensive expertise in equality matters and the BME consultant focus group recognised improvements since the interim board appointments had been made.
- At the end of the inspection visit the trust commissioned an external cultural review.
- Business cases were now being reviewed and acted upon.
- Therapy staff demonstrated a strong supportive culture within the department.

Vision and strategy

- The Trust sustainability review addressed the clinical and financial sustainability of the Trust moving forward. Integral to this was the trusts response to the community procurements with the redesign of both community and acute services to meet the changes in commissioning landscape. There was a focus on the redesign of urgent care services to create an urgent care village with increased ambulatory care and

improved provision for frail elderly. Included within this would be a move away from home visits by nursing teams towards a hub and spoke model incorporating increased medical outreach into nursing homes.

- The treatment of long term conditions would be increasingly managed in the community in order to create increased capacity within the acute trust. The plan was to develop and agree new clinical pathways that were more appropriate and cost effective. Integrated models of care for the frail elderly would decrease urgent, unplanned activity and as a consequence reduce admissions and improve patient experience. Flow through the acute trust would be optimised through the introduction of a single point of access, use of discharge to assess principles, tele health in the community and working with partners to support patients to manage their own condition.
- At the time of the inspection the trust had been led by an interim executive team with the exception of the Director of Nursing and the Medical Director. Interim management arrangements had been in place for the eight months prior to the inspection following the exclusion of three directors including the Chief Executive Officer.
- The Trust Development Agency (now NHS Improvement) had been and was continuing to support the trust through this challenging period.
- The interim team had begun to explore and develop options for the future to in line with national and regional initiatives to change the healthcare landscape in terms of the development of sustainable services, however, at the time of our inspection definitive outcomes had yet to be determined. This limited the trusts ability to demonstrate a clear vision and strategy for the organisation going forward

Governance, risk management and quality measurement

- The Board Assurance Framework was not subject to regular review in line with the Risk Management Strategy, i.e. it had not been reviewed by the finance, performance and investment committee; the audit committee or the Quality and Safety Committee in January or February 2016 and the Quality and Safety Committee did not meet in December 2015.
- There were concerns about the lack of consistency of regular meetings of groups and committees that support the Board and provide assurance. There was evidence that attendance was inconsistent and performance data in accurate.

Summary of findings

- Corporate risk registers were monitored through the monthly executive management team meetings instead of through the Board. However the trusts understanding, recording and monitoring of its risks required improvement.
- Risk management was identified on the Board Assurance Framework as a high risk with a control being interim support from NHS Improvement.
- Medicines governance arrangements in the Trust had changed since our previous inspection. The Chief Pharmacist was acting as the medicines safety officer and the Trust's medicines safety committee had been amalgamated into the Drugs and Therapeutics committee.
- It was not evident how this new structure would support the principles of the medicines safety alert 'Improving medication error incident reporting and learning, March 2014' with regard to identifying, developing and promoting best practice for medication safety.
- For example, there was no designated committee to lead on the review of medication errors throughout the Trust, and in the absence of a champion, a pilot initiative to collect data for the NHS Medicines Safety Thermometer had been discontinued.

Leadership of the trust

- The BME consultant focus group recognised improvements since the interim board appointments had been made but still reported perceived discriminatory behaviour towards senior consultants specifically relating to inappropriate practices during recruitment processes and inappropriate use of MHPS and disciplinary processes. The trust had instigated an independent investigation following the previous inspection, however, a number of senior consultants considered opportunities were missed in terms of the scope of the review.
- Consultants had since made the interim Chief Executive and Chair aware of their concerns at an MSC meeting in October 2015. Since then, the Chair of that group had been given assurances that MHPS procedures would be used appropriately.
- Since August 2015 the CEO, Chief Operating Officer, Human Resources Director and Deputy Director of Performance had been excluded from the trust followed an independent external investigation into three separate whistleblowing complaints received by the trust. No aspects of the whistleblowing complaints or investigation related to issues of patient care or safety.

- In the meantime there had been a number of interim directors supporting the executive team. The Director of Nursing and Quality was new to the trust from February 2015 but was having a positive impact in relation to the nursing agenda and nursing staff engagement.
- The Trust Development Agency (now NHS Improvement) had been supporting the trust through this difficult period.
- Clinicians from a BME background continued to raise concerns regarding differential treatment.
- Some staff felt there was a lack of visibility and direction from the executive team.
- Therapy staff demonstrated a strong supportive culture within the department.

Culture within the trust

- Recent appointments at director level had been viewed positively by staff.
- We heard from staff and their representatives that they had seen a positive shift in culture at executive level but they felt the pace of change was too slow.
- Some staff in ancillary roles felt undervalued and this had resulted in some groups of staff taking industrial action.
- Staff had a willingness and passionate to provide patients with good quality of care.
- At the last inspection there were an abundance of business cases which were not determined or actioned .This behaviour had recently ceased and all business cases were now being reviewed at executive level. Of the 34 business cases 27 had been approved, six were pending and one had been denied.

Equalities and Diversity – including Workforce Race Equality Standard

- There was no evidence of a vision or strategy regarding workforce race equality with no overall equality strategy for the trust beyond the implementation of EDS2 with an action plan that referred to the period 2012-15. No more recent documents have been produced to change/reinforce the trusts direction in this regard.
- The latest published objectives related to 2012-15. The trust was not compliant with Public Sector Equality Duty, which requires objectives to be reviewed annually and published every four years. The expectation is that the published equality figures (as at 31/03/2015) are used to assess performance and to form a baseline for new objectives and target setting. These should then be published. The cycle for 2016-17 was not under way.

Summary of findings

- It is a requirement within the national contract for trusts to publish their results for the Workforce Race Equality Standard. These have been neither produced nor published. The trust informed us that this was due to a misunderstanding of the requirements.
- Analysis of workforce equality data did not take place routinely or as part of Public Sector Equality Duty reporting.
- EDS2 assessments were made by the E&D lead rather than through internal and external consultation and the assessments had been utilised by the organisation as the framework for self-evaluation.
- Workforce equality statistics were produced and published annually. There were plans to produce the statistics for April 2015 to March 2016 in the next few weeks once all were known for the period. Workforce committee minutes showed that this requirement was discussed in a timely fashion and that there was a governance structure in place. An equality assurance group, which reported into the workforce committee and thereby into the Board met quarterly and had a mix of professional groups, and one new SAS BME doctor.
- Since September 2015 there was no evidence in the trust board minutes of strategic discussions regarding race equality. Whilst equality was discussed briefly in the context of the HR quarterly report that included references to the staff survey, no future direction had been discussed or set.
- The equality assurance group monitored progress against the EDS2 action plan and produced a RAG rated report. There was evidence of some quantitative outcomes measures being utilised including appraisal rates and using ESR data broken down by protected characteristic.
- Equality impact assessments were completed for policies and major service changes. Templates were readily available on the trust intranet.
- Following publication of the staff survey results regarding higher than expected violence against staff reported, the HR staff had triangulated result against incidents reported and grievance / Dignity at Work cases but found no correlation.
- There had been a recent appointment of a BME non-executive director with extensive expertise in equality matters.
- E&D training formed part of mandatory training and attendance was monitored accordingly.
- The staff survey results showed that of the 32 key findings, 10 were average when compared with other acute trusts, 13 were worse and 9 were better. Eighteen of 32 had higher BME scores than white.

Summary of findings

- In the staff survey the trust averaged 9% (National Average 10%) in the percentage of staff experiencing discrimination in previous 12 months. This was broken down to White 8% and BME 25%.
- The percentage of staff experiencing bullying and harassment from staff in the staff survey was 22% across the trust (slightly better than the national average of 24%), the score for white staff was 22% with BME staff reporting 25%. The score for medical staff, where BME doctors form the majority, was 40%.
- The percentage of staff experiencing violence from staff in the staff survey was 3% across the trust (National Average 2%) and White 3%, BME 10%.
- The BME consultant focus group recognised improvements since the interim board appointments had been made but still reported perceived discriminatory behaviour towards senior consultants specifically relating to inappropriate practices during recruitment processes and inappropriate use of MHPS and disciplinary processes. The trust had instigated an independent investigation following the previous inspection, however, a number of senior consultants considered opportunities were missed in terms of the scope of the review.
- Consultants had since made the interim Chief Executive and Chair aware of their concerns at an MSC meeting in October 2015. Since then, the Chair of that group had been given assurances that MHPS procedures would be used appropriately.
- There was no clear leadership around E&D issues at board level. The emphasis was on compliance, although this has not been achieved. Activity was reactive, rather than proactive.
- In response to these concerns being raised with the trust at the end of the inspection visit they have commissioned an external cultural review.

Fit and Proper Persons

- Fit and Proper Person Regulation was included within the trusts recruitment and selection policy. The procedure was initiated in March 2015.
- The procedure met the requirements with the exception of the reviews for non-executive directors.
- The interim files were being held centrally by NHS Improvement at the time of the inspection as they held the responsibility for recruitment of interim executives.
- Only four of seven files of executive and non-executive appointments since November 2014 were available for review.
- None of the files contained all the information mandated within the trust policy.

Summary of findings

Public engagement

- Trust board meeting minutes and papers were available to the public online which helped them understand more about the hospital and how it was performing.
- The hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. The friends and family test showed that the majority of medical wards scored over 95%of patients who would recommend the hospital to friends or a relative.
- The trust had news releases on its website pages to keep members of the local community up to date with current events. We observed that the news releases on the website were current and up to date.
- The Trust had undertaken a number of events titled “In Your Shoes” where patients and carers were invited to share their journey with the trust. The event highlighted a number of positive aspects of the care and treatment on the wards as well as a number of negative findings. We saw that the positive findings included good support from allied health professionals, openness of staff and good food. Negatives findings included slow discharge planning arrangements and lots of chaos around the wards.
- The NWRSIC encouraged previous patients with spinal injuries to visit the unit and meet with patients. These volunteers gave both patients and relatives encouragement.
- Friends and Family Test performance has shown an overall trend of improvement between July 2014 and January 2016.

Staff engagement

- Staff told us that there had been road shows held for staff to support them through the difficulties the trust was experiencing but many felt that as they were held in working hours this had barred them from attending.
- There had been attempts to establish various forms of staff network. Virtual networks exist for LGBT, disability and BME staff
- The previous E&D lead continued to work in the organisation and was the E&D representative for staff side. They were providing informed input to equality analysis for HR policies. There were low levels of uptake for staff networks and no evidence of alternative means of gaining feedback from BME staff or any other staff groups with protected characteristics.
- There was no evidence of consultation (internal or external) regarding EDS2 outcomes.
- There was no evidence of active staff engagement work with BME doctors, despite their prevalence in the medical workforce.

Summary of findings

Innovation, improvement and sustainability

- Improvement was seen in the areas which had been highlighted in the previous inspection report.
- Innovative practice was not widely evident as the organisation and staff were under considerable challenge to maintain safe and effective service delivery.
- The sustainability of the organisation in its current format was questionable and planning was underway to secure a better model of care for the future.

Overview of ratings

Our ratings for Southport and Formby District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Regional Spinal Injuries Unit	Good	Good	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Critical care	Good	Good	Good	Requires improvement	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Good	Good	Good
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Our ratings for Ormskirk District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Southport and Ormskirk Hospital NHS Trust

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

Overview of ratings

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Community health services for children, young people and families	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Community health urgent care services (MIU)	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall Community	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Outstanding practice and areas for improvement

Outstanding practice

- The NWRSI Centre had developed improvement in information for healthcare professionals. For example, following assessment, the outreach team had produced a document with written advice and instructions. This document had been developed by the NWRSIC by taking into account standards and protocols for SCI management practised nationally. This document has also been developed in co-operation and discussion with the outreach team at the Midlands Spinal Injuries Centre at Oswestry.
- The centre has been pivotal in providing training to other Spinal and Rehabilitation Centre's for the development of intrathecal baclofen pump services.
- The additional capacity the outreach service had brought to the centre had enabled patients referred to the centre from major trauma centres to be admitted faster. The length of referral to admission is now reducing ensuring patients are able to commence their rehabilitation sooner.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

- The trust must ensure that all executive and non-executive appointees since November 2014 have been reviewed and documentation is held in line with the trusts policy for recruitment and selection in regards to the Fit and Proper person regulation.
- The trust must improve the management of risk including the embedding of the revised processes for serious incident reviews including the use of RCA by trained staff and meet the timescales of their policy for Board oversight.
- The trust must improve the adherence to the use of and escalation resulting from the use of the Early Warning Score electronic system.
- Address the musts and should for the locations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Family planning services Maternity and midwifery services Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors **The provider must ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Family planning services Maternity and midwifery services Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (2)(b)** **The provider must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Rsk assessments relating to the health , safety and welfare of people using the service must be completed and reviewed regularly by people with the qualifications, skills, competence and experience to do so.**