Care Quality Commission

Lancashire Teaching Hospitals NHS Foundation Trust

Royal Preston Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Requires improvement
Services for children and young people	Requires improvement
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Royal Preston Hospital provides a full range of district general hospital services including Emergency Department, critical care, general medicine including elderly care, general surgery, oral and maxillo-facial surgery, ear nose and throat surgery, anaesthetics, children's services, women's health and maternity, and several specialist regional services including cancer, neurosurgery and neurology, renal, plastics and burns, rehabilitation, and the major trauma centre for Lancashire and South Cumbria.

The hospital has around 700 beds, operating theatre complex, outpatient suites, and education facilities.

We inspected the hospital as a follow up to the inspection in July 2014 where the hospital was found to require improvement in the safe, responsive and well led domains and good in the effective and caring domains. We visited Royal Preston Hospital between 27 and 30 September 2016.

Following this inspection we have rated the hospital as requires improvement overall and the trust needs to make improvements. Staff were noted to be caring and patient focused and the caring domain was rated as good in all service areas.

We saw several areas of outstanding practice including:

In Outpatients and diagnostic imaging the introduction in dermatology of a computerised diary colour codes patients by procedure enabling the service to plan a block of 12 week care in one go to suit the requirements of each patient. It also flags and calculates potential breeches giving better patient flow, facilitating comprehensive audit of care provision and outcome of treatment.

In Critical Care the trust had launched the Sleep Improvement in Adult Critical Care Programme. Disturbed sleep in critical care patients is associated with delirium, in which patients become confused, restless and experience hallucinations. This can delay their recovery from critical illness. The trust recognised this and identified the potential disturbances to sleep. To minimise disruption to patients during the night, they offered eye masks and earplugs, dimmed lights, anticipated empty infusion alarms, turned down the volume on medical equipment and phones and encouraged staff to talk away from the bedside. Staff were also reminded to check regularly for signs of delirium. The project and associated resources were shared with neighbouring critical care networks and at national meetings. An initial research study showed that making small changes caused a 50% reduction in patient delirium and significantly improved the quality of sleep experienced by patients. The study had won an initiative award at the National Nursing Times Awards.

However there were areas for improvement. Importantly, the hospital must:
In Urgent and Emergency Care services;

- Ensure access to the main entrance paediatric waiting area is limited to reduce the risk of children exiting the area through the automatic doorway.
- Ensure intravenous fluids are stored securely and daily checks are completed with actions to address issues identified, completed.
- Ensure mandatory training, including safeguarding, compliance reaches and consistently achieves the trust target.
- Ensure clinical staff are aware of and adhering to the requirement for senior review of specific patient groups prior to discharge from the ED
- Ensure appropriate signage is displayed in areas where close circuit television cameras are used.
- Ensure action plans following CEM audits target areas of poor performance and improve practice.
- Improve performance, particularly in relation to the department of health four hour target; wait times following a decision to admit, ambulance handovers.

Summary of findings

- Ensure version control for policies, procedures and guidance is robust and that these are kept up to date and reviewed regularly.
- Ensure the department has a dedicated risk register with start dates, timelines, mitigating action and responsible person with review dates included.

In Medicine;

- Ensure that all staff receive appraisals and complete mandatory training to enable them to carry out the duties they are employed to perform.
- Ensure that records are kept secure at all times, so that they are only accessed by authorised people.
- Ensure procedures in place around medicine management are robust and that policies are followed.
- Ensure the risk registers are consistent and demonstrate mitigating actions and review dates

In Surgery;

- Take appropriate actions to improve staff training compliance in areas such as safeguarding training and life support training.
- Take appropriate actions to ensure that patients requiring escalation, as part of the national early warning score system (NEWS), are appropriately escalated by staff.
- Take appropriate actions to improve compliance against 18 week referral to treatment standards.
- Take appropriate actions to reduce the number of cancelled operations and the number of patients whose operations were cancelled and were not treated within the 28 days.

In Maternity and Gynaecology;

- Ensure midwifery and support staffing levels and skill mix are sufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient.
- Ensure there is a safe system for protecting babies from abduction.
- Ensure all necessary staff completes mandatory training, including Level 3 safeguarding training and annual appraisals.
- Ensure that the assessment and mitigation of risk and the delivery of safe patient care is in the most appropriate place.
- Complete risk assessments for midwives carrying medical gases in their cars and develop a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.
- Ensure that all staff receive medical devices training to ensure all equipment is used in a safe way.

In Critical Care;

- Ensure that escalation procedures are followed appropriately across the hospital where patients' National Early Warning Scores (NEWS) are greater than five and the patient may need to be assessed for admittance to the critical care unit.
- Ensure that any patients admitted to Ward 2A, who are assessed as Level 2 high dependency patients, receive nursing care at a ratio of 1:2 in accordance with national standards.
- Address action points on a gap analysis that showed that there was no availability for endoscopy for urgent gastro intestinal bleeds 24 hours a day.

In Children and Young People's services;

- Ensure that staffing levels in neonatal and children's services are maintained in accordance with national guidelines.
- Ensure that all relevant staff having regular contact with children, as defined by intercollegiate guidance, complete level three safeguarding training.
- Ensure that indicators for managing the changing condition of ill children are consistently used and responded to appropriately on the children's ward.

Summary of findings

- Ensure that the isolation room used on the children's ward is free from access to ligature points
- Ensure that patient records are kept securely in the children's out patients department.
- Ensure that checks on emergency resuscitation equipment, are completed and accurately recorded on the neonatal unit.
- Ensure that secure access to the neonatal unit and children's ward is maintained at all times by staff, parents and visitors.

In Outpatients and Diagnostic Imaging;

- Ensure that clear processes and structures are in place for the management and reviewing of governance, quality and risks.
- Review the processes for managing access and flow for outpatient services to ensure patients are not put at risk.
- Ensure staff complete mandatory training as per the trust policy.

In addition the trust should:

Urgent and Emergency Services

- The service should work to embed the forthcoming escalation process to support staff when capacity issues arise.
- The service should have access to information in languages other than English
- The service should improve attendance at monthly ED safeguarding meetings

Medical Care (including older peoples care)

- The service should ensure that patients are discharged as soon as they are fit to do so.
- The service should ensure that patients are not moved ward more than is necessary during their admission and are cared for on a ward suited to meet their needs.
- The service should consider improving the environment of the discharge lounge to maintain patient's privacy and dignity.
- The service should ensure that patients have access to pressure relieving equipment at all times.
- Consider implementing formal procedures for the supervision of staff to enable them to carry out the duties they are employed to perform.

Surgery

- The service should take appropriate actions to maintain safe nurse staffing levels across the surgical wards.
- The service should take appropriate actions to improve the general environment in the theatre areas.
- The service should take appropriate actions to improve staff appraisal completion rates.
- The service should take appropriate actions to improve infection rates following knee replacement surgery.

Critical Care

- The trust should ensure intravenous fluids are stored appropriately and are not accessible to patients or visitors on the critical care unit.
- The trust should make every effort to secure funding to expand the critical care unit in order to bring bed spaces within the recommended guidelines, make the flooring safe and to reduce the level of bed occupancy.
- The Critical Care Governance Team should follow up the request for a review of the risk rating of the lack of a specialist critical care trained pharmacist on a weekend.
- The trust should ensure that all staff in critical care receive mandatory training so that trust mandatory training targets are met.
- The trust should ensure that all staff in critical care (especially nursing staff) receive an annual appraisal, in line with trust targets.

Summary of findings

- The service should ensure that action plans arising from audits are kept up to date until complete or actions should be removed.
- The service should ensure that GPICS guidelines for 50% of nursing staff to have undertaken a post qualification course in critical care nursing is achieved as soon as possible.
- The trust should for any mitigating actions that could reduce the number of delayed discharges from critical care.
- The trust should look for ways that Speech and Language therapy (SALT) assessments can be carried out in a more timely manner.

Maternity and Gynaecology

- The service should improve the recording of the review dates and version control of all policies and procedures.
- The service should strengthen the risk registers to support the management of risk.
- The service should improve attendance at governance meetings.
- The service should consider the safe storage of patient's notes on the gynaecology wards.
- The service should consider the safe storage of expressed breast milk on the postnatal ward.
- The service should consider the dignity and privacy of patients within the clinical areas, especially where curtains are used between bed areas and waiting areas that are positioned near procedure rooms.
- The service should continue to monitor consultant labour ward presence with an aim of extending weekday and weekend cover.
- The service should ensure that the capacity within the obstetrics and gynaecology theatres prevent delays in patient procedures.
- The service should continue to ensure that processes for the storage, recording and traceability of fetal pregnancy remains on the gynaecology wards are robust.
- The service should improve staff annual appraisal rates.
- The service should increase staff training uptake for Female Genital Mutilation (FGM) training.
- The service should work to better understand the variation in unplanned home birth rates to ensure safety of patients and babies.

Services for Children and Young People

- The service should use an evidence-based dependency tool to manage appropriate staffing ratios for nursing care on the children's ward.
- The service should appropriately meet the continuing needs of patients who are admitted for child and adolescent mental health services, with adequate support and training for nursing staff where this is required.
- The service should accurately record the completed temperature checks for breastmilk fridges and stores on the neonatal unit.
- The service should maintain appropriate environmental temperatures on the children's ward.
- The service should maintain neonatal guidelines in an up to date and accessible format for staff to use on the neonatal unit.
- The service should that complete and maintain appropriate records for staff supervision and appraisals on children's and neonatal wards
- The service should collect patient feedback responses on the children's ward using the NHS Friends and Family Test

End of Life services

- The service should improve compliance for mandatory training particularly safeguarding, life support and care of the dying education.
- SPC staff appraisal rate should meet the trust target of 85%.
- The service should address the low numbers of registered nurses who were trained in delivery of end of life care, particularly surgical staff.

Summary of findings

- The service should create a system for monitoring numbers of staff trained in syringe driver use to assure competency.
- The service should consider they take steps to meet the needs of patients by providing a seven day specialist palliative care service.
- The service should review staffing levels to ensure they are adequate to maintain the excellent results of the donor retrieval team.

Outpatient and diagnostic imaging services

- The service should continue to monitor and review the procedures for caring for vulnerable patients attending for cancer therapy.
- The service should consider improving the environment in the Outpatients department to ensure privacy and dignity is maintained.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating
Urgent and emergency services	Requires improvement

Why have we given this rating?

In our previous inspection in July 2014 report, we gave Urgent and Emergency Services an overall rating of 'Good'. Following this inspection, we have changed this rating to 'Requires Improvement'. This was because:

- The entrance and exit from the paediatric waiting area opened automatically onto a thoroughfare for vehicles, allowing children to exit potentially unnoticed.
- Although medicines and controlled drugs were stored correctly in the emergency department (ED), we found intravenous fluids were not stored securely in the emergency medical decision unit (EMDU). We also found temperature ranges for fridges storing medicines at low temperature were not always checked in the EMDU and where they were found to be out of range action to address the issue was not taken.
- Compliance with staff training was low with only 42% of doctors and nurses compliant overall.
- Not all medical staff were aware of the need to obtain senior clinical review prior to discharging certain high risk patients such as those suffering chest pain.
- Whilst local guidance was in place and accessible, we found that review and update processes were not robust and some guidance appeared to be several years out of date.
- Although the department took part in national audit programmes, we saw little evidence of action to address poor results. Instead staff relied on incidents of poor practice to help them identify required action.
- We noticed that patients brought to the department by ambulance sometimes had to wait in a corridor which impacted on their privacy and dignity. Staff tried to minimise the impact by creating as much space as possible between these patients.

Summary of findings

- Despite making attempts to manage the flow of patients through the department, targets for providing care and treatment in a timely way were consistently not being met.
- Although leaflets were available which provided information for people following discharge from the ED, none of these were displayed in languages other than English. When we asked staff about this they were unsure how to obtain leaflets in other languages.
- Although risk registers were in place, these did not include enough information and were not specific to the ED. Some risks such as issues with meeting national targets were not included.
- Closed circuit television (CCTV) was in use but we saw no evidence of signage to warn people about this.
- Governance was in place in the department but this was not robust. For example, data was collected centrally but not broken down specifically to departmental level. This left us concerned that staff were unaware of basic governance matters such as overall cleanliness or record quality.

However:

- There was an open, no-blame culture.
- Staffing was adequate for both medical and nursing staff.
- Areas were visibly clean and tidy with cleaning staff available 24 hours a day to ensure areas were cleaned, decontaminated and available for use as soon as possible.
- Despite our findings in relation to the requirement for senior clinical review for some patients, other risks to patients were managed through triage, rapid assessment, escalation of deterioration and post discharge reviews.
- Safeguarding was managed centrally; with useful flow charts and support from lead nurses should staff have any queries.
- Guidelines were based on national guidance, pain was monitored and pain relief was available if required.

Summary of findings

- A range of food and refreshments were available for patients and loved ones visiting the department.
- Staff competencies were maintained using information sharing and teaching. Revalidation was monitored regularly.
- ED staff worked with a range of staff from different teams both within the hospital and externally to ensure a multi-disciplinary approach to care. Services were available throughout the week and staff had access to all the information they required to provide care for patents.
- Staff were aware of the need for consent and assessment of patients lacking capacity. They documented capacity assessments and made decisions based on patient best interests for those unable to provide consent.
- Patients told us the care they received was 'great' and that staff were 'lovely'.
- Patients completed surveys which showed 73% would recommend the service to friends and family members. In another survey 100% of 31 people surveyed said they were happy with the care provided.
- In the CQC Accident and Emergency Survey 2014, patients said they were given enough time to discuss their problems with staff, had confidence in staff, felt they could summon staff if needed and felt involved in their own care. They also felt staff gave them enough privacy and dignity.
- We saw staff caring for patients in a kind and empathetic manner, providing blankets to ensure they were comfortable.
- Staff were familiar with the needs of local people. Telephone translation and web based video sign language translation were available for patients whose first language was not English or who had hearing problems, a wide range of chaplaincy services were available and services for patients living with dementia were also provided.
- Complaints were managed through an established process with changes made to improve services where possible and information circulated to staff.

Summary of findings

- The culture was positive, and we saw that staff at all levels formed a cohesive team built on peer support and dedication.
- Leaders engaged with staff at all levels and helped during busy periods.

Medical care (including older people's care)

Requires improvement

We rated medical services at Royal Preston Hospital as requires improvement overall because:

- There were staff vacancies in most areas and there were occasions on wards when there had been a reliance on agency or bank nurses as well as locum doctors. Data provided showed there were times when the staffing levels were less than 80%.
- Overall compliance with mandatory training for all staff was below trust target. The trust target was 80%.
- There was a risk that personal information was accessible to members of the public as patient's records were not always stored securely.
- There were systems for handling and disposing of medicines however staff did not always evidence they followed policy and procedure and improvement was required.
- Clinical staff had access to information they required, for example diagnostic tests and risk assessments. However, we found patients records were left unsecured on the wards we visited.
- There were issues with access and flow across the medical wards with high bed occupancy rates and delayed discharges due to patient choice and complexities.
- Some patients were being nursed in escalation or non-speciality beds and were moved on more than one occasion during their hospital stay with some moved during the night.
- Recent audits performed showed further improvements were required in the care of patients with diabetes or who had suffered a heart attack or stroke.
- There were governance structures in place which included a risk register. However there were inconsistencies across the divisional and trust risk register.

Summary of findings

- Policies and procedures were in place however we are not assured all of these reflected current practice as they were not always reviewed and updated as planned.

However:

- The trust were monitoring and taking actions regarding staffing levels including rolling recruitment, including overseas and regular monitoring of staffing levels during the day to help mitigate the risk.
- Wards were visible clean and staff followed good hand hygiene practices.
- All staff were aware of the trusts values and vision.
- Staff were proud of the work they did and well supported by their managers and worked collaboratively together to ensure patient were cared for.
- Staff treated patients and their relatives with respect and dignity and communicated with them effectively. Patients we spoke to were happy with their care, felt informed, and were involved in care planning.

Surgery

Requires improvement

The surgical services were previously rated as requires improvement for safe, responsive and well-led in November 2014 following our last inspection. This was because we had concerns around staffing levels, mandatory training compliance and poor compliance against 18 week referral to treatment standards. At this inspection we rated the surgical services at the Royal Preston Hospital an overall rating of Requires improvement. This was because: -

- During this inspection, we found that although some improvements had been made, there were still areas where further improvement was needed.
- Most staff had completed mandatory training. However, less than 50% of staff had completed adult safeguarding training and the proportion of staff that had completed adult and paediatric life support training was below the hospitals expected levels.

Summary of findings

- Most staff had completed their annual appraisals (71%), but the hospitals internal target for 82% appraisal completion had not been achieved.
- Most clinical areas were clean and well maintained. However, we found some theatre areas were aged and displayed signs of wear and tear.There was no scheduled refurbishment programme in place to upgrade or refurbish the theatre areas in the near future.
- The national early warning score system (NEWS) audit from May 2016 showed a patient monitoring plan was completed and followed on 46% of occasions and patients were appropriately escalated on 48% of occasions. This meant there was a potential risk that deteriorating patients may not receive timely care and support.
- The surgical wards did not have sufficient numbers of substantive trained nursing and support staff. Staffing levels were maintained through the use of bank and agency staff and through the daily management and deployment of the existing staff.
- A recruitment programme was underway and a number of nursing and healthcare assistant posts had been appointed. However, the majority of nursing recruits were newly qualified staff and were scheduled to commence employment between January 2017 and March 2017.
- The services performed worse than the England average for 18 week referral to treatment (RTT) waiting times between August 2015 and June 2016 for most surgical specialties. There was a worsening trend in performance which meant the number of patients waiting longer than 18 weeks for treatment had steadily increased since the start of 2016.
- As part of the surgical division RTT recovery plan, a review identified seven specialty areas with an imbalance in capacity and demand that would lead to increasing waiting lists. The recovery plan included actions to improve 18 week wait times and to improve patient flow and efficiency in the wards and theatres by March 2017.

Summary of findings

- The proportion of elective patients whose operations were cancelled and were not treated within the 28 days across the trust was significantly worse that the England average between July 2014 and June 2016.
- Performance shortfalls were reported on monthly performance dashboards and routinely reviewed at departmental and divisional meetings. However, the services had failed to implement timely and effective remedial actions to address these issues in order to improve the services.
- A new divisional structure had been in place since December 2015 and most staff felt this was a significant improvement from the previous organisational structure. However, the governance and performance reporting systems were still being imbedded as a result of personnel changes and new reporting structures.

However, we also found that: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately.
- Patients spoke positively about the care and treatment they received. Patient feedback from the NHS Friends and Family Test showed that most patients were positive about recommending the surgical wards to friends and family.
- The services participated in national and local clinical audits and performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures.
- There was effective teamwork and visible local leadership within the services. Staff were positive about the culture within the surgical services and there was routine public and staff engagement.

Summary of findings

Critical care

Requires improvement

We have previously inspected the hospital in July 2014 and gave critical care services an overall rating of good. Following this inspection we rated critical care services at Royal Preston Hospital overall as requires improvement because:

- Eighty three percent of the beds on the unit were not compliant with the Department of Health Building Note 04-02 for Critical Care Units that specifies the minimum amount of bed space required to safely locate and utilise required equipment.
- Plans to expand and rebuild the unit to meet required bed spaces and provide adequate storage, and staff and visitor facilities had not been undertaken due to financial constraints.
- Flooring in the unit was in a poor condition and presented a tripping hazard and potential infection control risks.
- There was a shortage of pharmacists, dietitians and physiotherapists to meet the needs of patients across seven days a week.
- Mandatory training uptake levels were low for some subjects, including safeguarding children and adults training.
- Appraisal rates were low at 62% and this was a lower rate than at the previous inspection.
- Audits were not always followed up with action plans and a number of action plans had not been update for years in some cases.
- The service was not meeting the Intensive Care Standards guidelines for 50% of nursing staff to have undertaken a post-graduate qualification course in critical care nursing.
- There was limited monitoring of patient satisfaction.
- Seventy one percent of patients admitted to the critical care units experienced a delay in their discharge.
- Bed occupancy was consistently higher than the England average.
- Daily emergency admissions exceeded the anticipated rate for which beds were reserved.

However;

- The critical care services were well-led and staff were aware of the trust's vision and values.

Summary of findings

- We found that there were governance frameworks in place and risks were appropriately identified and monitored.
- There was clear leadership throughout the service and staff spoke positively about their leaders.
- Staff were able to report incidents and were knowledgeable about the types of incident they should report.
- We saw evidence that learning from incidents and complaints was routine and this learning was disseminated.
- Infection control was effectively managed and the department was visibly clean. Routine infection control audits were undertaken.
- Nurse and medical staffing was sufficient to meet patients' needs.
- Patients received effective care and treatment that followed national clinical guidelines, was tailored to their individual needs, and was delivered by competent and professional staff.
- The service participated in local and national audits.
- Staff sought appropriate consent from patients before delivering treatment and care.
- Staff were knowledgeable about the Mental Capacity Act and considered this where relevant.
- Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality.
- Patients spoke positively about the way staff treated them.

Maternity and gynaecology

Requires improvement

At the last inspection in July 2014 we rated the service as good overall. Following this inspection we rated this service as Requires Improvement because:

- The system for protecting babies from abduction was not robust. Due to a shortage of electronic baby security tags, not all babies were issued with a tag on the postnatal ward and concerns regarding the level of observation at the one main entrance, through the antenatal ward, to

Summary of findings

get to the postnatal ward. Baby security issues were raised with the trust at the time of our visit, immediate action was taken, and all babies were tagged before we left site.

- The system for recording and storing fetal pregnancy remains on the gynaecology ward was not robust. This was immediately raised with the trust and at the time of the unannounced visit, we observed changes in practice to assure us that pregnancy remains were stored safety and sensitively and recorded appropriately.
- All staff reported a shortfall in staffing and an increasing quantity of work and activity within the service. Management told us that the midwifery staffing levels had not been formally reviewed since 2011. However they were waiting for the Birthrate Plus (a national tool available for calculating midwifery staffing levels) review and report Staffing levels was also raised as a concern at the last CQC inspection in 2014. Although it was noted that since2014, there had been an increase in 10 full time midwives.
- Due to staffing issues and sickness absence rates, there was a heavy dependence on midwives working extra hours. The trust did not use agency staff but used their in-house bank staff on an ongoing basis. Additional midwifery staffing was provided by midwives working over and above their normal working hours.
- All midwifery staffing, including community were flexed to meet the needs of the service user. Managers were aware of the staffing shortfall and recruitment was underway; however, the current measures in place were not sustainable and insufficient to mitigate the risk of harm.
- Due to the pressures of work, staff morale was low but staff of all professions supported each other well to work as a team. There was a desire to provide the best care they could to the patients and the inability to achieve this led to dissatisfaction amongst midwives.
- Gynaecology beds were used on a daily basis, including weekends, for patients with other medical, surgical or orthopaedic conditions. This resulted in access and flow issues and delays in some gynaecological procedures.

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- Obstetric consultant cover for delivery suite was 80 hours per week. The trust were monitoring this closely as it did not meet the recommended hours required on delivery suite (Standards for Safer Childbirth, 2007). This was also a concern raised at the last CQC inspection in 2014.
- There was only one dedicated obstetric theatre, set up every day for obstetric emergencies. There was lack of a second dedicated obstetric theatre. Elective caesarean sections were usually performed in one of the two adjoining gynaecology theatres, which could lead to delays of operative procedures.
- Not all staff attended annual mandatory training or received their annual appraisal
- There was some discrepancy among senior staff about what level of safeguarding training provided to staff.
- Expressed breast milk (EBM) was not securely stored. Fridge temperature recordings were inconsistent.
- The trust did not complete any risk assessment for midwives carrying medical gases in their cars and did not have a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.
- Policies and guidelines were not robustly updated. Of the maternity polices and guidelines reviewed, 30% were out of date.

However:

- Care in the Preston Birth Centre was provided in a calm, relaxed and spacious environment that had been specifically designed and equipped to support normal births.
- There were clear systems for reporting incidents and managing identified risk within the service.
- The service was proactive in learning from complaints and concerns.
- Access and flow issues on the gynaecology wards were managed well by the clinical lead who had good oversight to move patients accordingly and work flexibility across all areas.
- Daily multidisciplinary team (MDT) staff safety huddles took place.

- Medicines were delivered, stored and dispensed safely.
- The wards were adequately maintained and equipment was readily available and fit for immediate use. Resuscitation equipment was available and fit for use by suitably trained staff.
- We found that committed and compassionate staff delivered maternity and gynaecology services. All staff treated patients with dignity and respect. People we spoke to were positive about the care they had received.
- Gynaecology staff informed us that referral to treatment times met the national recommendations, with rapid access to clinics available.

Services for children and young people

Requires improvement

At the last inspection in July 2014 the service was rated as Good overall. At this inspection we rated this service as requires improvement overall because:

- Nurse staffing levels on the children's ward did not reflect Royal College of Nursing (RCN) standards (August 2013) and the ward was short staffed on a regular basis, however staff numbers were reported to senior managers on a daily basis.
- Nurse staffing levels on the neonatal unit did not meet standards recommended by the British Association of Perinatal Medicine (BAPM), with managers advising that they were 80% compliant with these.
- Paediatric early warning scores were not actioned consistently and we saw some evidence that actions were not recorded when a patient's score changed from amber to red.
- There were insufficient staff available to provide one to one nursing supervision for patients admitted for Child and Adolescent Mental Health Services. Staff reported frequent additional demands in providing for the care needs of these and other patients whose needs were highly complex.
- Staff working with children in various roles, including nursing staff, reported they had completed level two safeguarding training only, which was below nationally recommended

Summary of findings

levels for this training. In addition, the trust's training records were inconsistent with ward training records in order to accurately confirm this.

- We saw evidence that checks on emergency resuscitation equipment were not consistently documented on the neonatal unit, with checks on the emergency transfer incubators and special care emergency box incomplete
- Records in the children's outpatient department were left unsecured in an administrative area overnight, where there was potential for public access when the department was unsupervised after clinic hours.
- Appraisal rates for nursing staff did not meet the trust target on the children's ward and some nurses said they had not fully completed their preceptorship supervision.
- The children's community nursing service only provided cover during weekdays, meaning that some children requiring continued treatment after their discharge needed to come back to the ward at weekends.
- Physiotherapy services for the children's areas did not use competency tools and general physiotherapy staff who supported the on call service lacked confidence in paediatric techniques.

However:

- Risks were identified and managed through a risk register, with systems in place to share learning with staff from incidents that had occurred.
- There were sufficient numbers of staff available on every shift who had completed advanced paediatric life support training for the children's ward and 98% of staff on the neonatal unit had completed newborn life support training.
- A paediatric staffing review paper had identified the shortage of nursing staffing on the children's ward and recruitment had already started, based on these recommendations. A recruitment programme for the neonatal unit had previously been implemented during 2015, towards meeting national standards for staffing.

Summary of findings

- Medicines were stored safely in all ward and department areas, with staff following clear protocols for recording and administering medications.
- Ward areas on children's and neonatal unit, also the children's outpatient department, were visibly clean and orderly, with staff working in accordance with infection control procedures.
- A number of care pathways were in place which followed national guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Child Health and Paediatrics (RCPCH). Specific development had been undertaken which supported young people with diabetes and epilepsy during their transition from children's to adult services
- A targeted development in response to outcomes from the National Neonatal Audit Programme had resulted in improved breastfeeding rates.
- We saw many examples of multidisciplinary team working and communications in place with providers of services external to the trust.
- Complaints were at a low level and were mostly about waiting times
- Staff worked hard to deliver the best care they were able to, despite frequent staff shortages. There was a positive culture of staff supporting each other and covering extra shifts to provide nursing care and ensure rotas were filled.
- Staff reported that new leadership had brought some changes and felt more assured that the day to day challenges in paediatrics and neonatal services were now being acknowledged 'from the top'.

End of life care

Good

At the previous inspection in July 2014 we rated this service as good overall at both hospitals. At this inspection we will only report on End of Life services within the Royal Preston Hospital report as the service delivered is by the same team across both hospital sites, however we did inspect both hospital sites. Following this inspection we have maintained this good rating because:

- There was good use of the individualised plan of care document throughout the hospital. All

Summary of findings

health care records were completed to a high standard to ensure patient safety. There was evidence of comprehensive risk assessments regularly performed and patients' goals and wishes were recorded.

- There was evidence of changes and improvements made as a result of feedback from patients and other staff.
- The palliative care team delivered training to all levels of staff, using a variety of teaching methods to capture the maximum staff available. Online guidance was provided via the trust intranet that ensured all staff had access to the most current information at all times.
- The end of life care (EOLC) team demonstrated excellent management of patients in their last days/hours of life. The team had used the National Institute for Health and Care Excellence (NICE) Care of the Dying guidance to develop a 'Think CLEAR' policy for all staff to follow. The team had performed on or better the national average on 11 out of 13 of the key performance indicators on the 2016 Dying in Hospital Audit.
- The team attended daily multidisciplinary team meetings across the hospital specialities in order to provide knowledge and input into patients' end of life care. The hospital team also participated in local and national groups to share information and learn from peers.
- Staff respected patients and their relatives and valued them as individuals. The care provided by the palliative care team was person centred and the culture within the team reflected this. All interactions between staff that we witnessed were patient centred and displayed compassion and respect.

However:

- The team were not providing a seven-day palliative care service that meant rapid discharge between Friday and Monday could not always be facilitated. This meant that some patients may not die in their preferred place.
- Due to staffing difficulties, the number of eye retrievals had decreased in recent months.

- The educational facilitator was having difficulties ensuring an end of life link nurse was available on every ward, due to staff movement within the hospital.
- Staff compliance with mandatory training and appraisal was below the trust target.

Outpatients and diagnostic imaging

Requires improvement

At the previous inspection in July 2014 we rated this service overall as requires improvement. Following this inspection we have maintained the overall rating because:

- The outpatients and diagnostics service was predominantly managed through the diagnostics and support services division. However key outpatient departments such as orthopaedics and ophthalmology were under a separate management structure. The recent changes in the divisional structure had led to some lack of clarity in terms of performance and governance.
- At our last inspection we found staff had not received clinical supervision, as required by the hospital's own policy and procedures. At this inspection we found this was still the case. Some staff told us that they had regular morning briefings and managers were accessible but they had not received and the trust did not provide details of staff uptake of clinical supervision.
- At our last inspection we found concerns within the ophthalmology department; clinics were sometimes cancelled at short notice and frequently ran late. At this inspection we found there were still issues regarding medical staffing and access to services in ophthalmology. In Ophthalmology there had been follow- up capacity pressures which had led to service governance concerns. The service had reported two serious incidents related to delays in accessing care and treatment.
- The environment was very cramped and did not assist staff in meeting the needs of individuals by providing appropriate consultation areas.
- The trust performed worse than the England average for referral to treatment times for non-admitted referral to treatment pathways in October 2015 and remained below the average

Summary of findings

each month to June 2016. Of the 16 separate specialties reported nine were below the England average, the lowest scoring being neurosurgery at 71%.

- For incomplete pathways of the 16 separate specialties reported, nine were below the England average, the lowest scoring being plastic surgery at 75%.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was worse than the standard for three of the four most recent quarters.
- Although there was a clear process for reporting and investigating incidents, staff told us they had not received outcomes of incidents submitted. We found that improvements were required by the trust to ensure that staff received regular feedback on incidents.
- We found some areas did have significant vacancies such as radiology and ophthalmology. Overall staffing numbers and skill mix met the needs of the patients.
- Care provided was evidence based and followed national guidance. Patients were treated with dignity and respect by caring staff. Patients spoke positively about staff and felt they had been involved in decisions about their care.
- Across outpatients and imaging services we found there was good local leadership and staff were committed to meeting the needs of their patients. Overall staff worked well as a team and supported each other. However we noted the recent changes to the directorate structures had had an impact on frontline staff with some staff unsure about reporting structures.

Royal Preston Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to Royal Preston Hospital

Royal Preston Hospital provides a full range of district general hospital services including Emergency Department, critical care, general medicine including elderly care, general surgery, oral and maxillo-facial surgery, ear nose and throat surgery, anaesthetics, children's services, women's health and maternity, and several specialist regional services including cancer, neurosurgery and neurology, renal, plastics and burns, rehabilitation, and the major trauma centre for Lancashire and South Cumbria.

The hospital has around 700 beds, operating theatre complex, outpatient suites, and education facilities.

Our inspection team

Our inspection team was led by:

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

Acting Head of Hospital Inspections: Lorraine Bolam, Care Quality Commission

The team included eight CQC inspectors, a pharmacy inspector, two assistant inspectors, an inspection planner and a variety of specialists including an emergency department Consultant and nurse, Consultant Geriatrician/General Physician, medical nurse, theatre manager, consultant anaesthetist, Lead Nurse Acute Care Team and Hospital at Night team, Head of Midwifery/ General Manager, Matron Maternity, Nurse Consultant/ Advanced Paediatric Nurse Practitioner, Consultant in Clinical Oncology, Clinical Nurse Specialist Palliative Care, Urological and Surgical services nurse, Radiology General Manager, Senior Quality and Risk Manager, Director of Nursing, Equality and Diversity specialist, Specialist Community Paediatric Physiotherapist, gynaecology nurse and an expert 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?

Detailed findings

• Is it well-led?

The inspection team inspected the following eight core services at Lancashire Teaching Hospitals NHS Foundation Trust:

• Accident and emergency

• Medical care (including older people's care)

• Surgery

• Critical care

• Maternity and gynaecology

• Services for children and young people

• End of life care

• Outpatients

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 spoke with people who used the service and the people close to them and we also met with representatives of the Protect Chorley and South Ribble Hospital Campaign. 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 Lancashire Teaching Hospitals NHS Foundation Trust

Facts and data about Royal Preston Hospital

The trust serves a local populationof 390,000 living in South Ribble,Chorley, and Preston boroughs.The health and deprivation of people in Lancashire as a county varies, with just over half of the health indicators worse than theEngland average, such as bingedrinking adults and life expectancy

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Urgent and emergency services

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

Information about the service

Urgent and emergency services are provided at Royal Preston Hospital by the emergency department (ED) under the trust's acute medicine directorate.

The ED operates 24 hours a day, seven days a week. Between April 2015 and March 2016, the department saw 79,254 patients, of which 16,734 were children up to the age of 16 years. On average, during this time, 217 people attended the ED each day.

Prior to April 2016 the trust operated two emergency departments. In April, the trust's other ED based in Chorley was changed to an Urgent Care Centre. This resulted in the ED at Preston accepting patients from a wider geographical area. On average, the ED at Preston saw 332 patients each day following this change.

The emergency department is a major trauma centre, accepting adult patients with more severe injuries following trauma. These patients may be brought to hospital directly following the incident, or transferred from other hospitals. There is a helipad on site.

The department does not provide major trauma care for children. Instead more severely injured children are taken by ambulance or helicopter to a regional children's hospital if their condition allows them to travel. If not, they are stabilised and then treated or transferred in line with their needs.

There is a designated entrance for patients brought in by ambulance, who wait to be triaged in a designated cubicle or the main corridor before being assigned to a suitable area. Ambulatory patients wait in an adult or paediatric waiting area before being called to a triage room when appropriate.

Following triage, patients receive care and treatment in three main areas: minor injury/illness, majors and resuscitation bays.

Patients with minor illnesses or injuries are treated in one of eight bays. If patients are ambulatory, they may be asked to wait for treatment in the main waiting area. People with more serious illness or injury are seen and treated in the 'majors' area which has seven bays or in one of four resuscitation bays. One of the resuscitation bays and a cubicle in the major's area are both suitable for children.

One resuscitation bay is assigned as the major trauma bay, situated directly behind a designated computed tomography (CT) scanner room.

The department also has access to an emergency medical decision unit (EMDU). This unit has room for 20 patients with additional capacity for ambulatory patients in a 'day wait' area.

We visited the ED and the EMDU during our inspection. We spoke with 12 patients and carers and 19 staff from different disciplines including clinical directors, doctors, matrons, nurses, emergency and advanced nurse practitioners, health care assistants, reception and domestic staff. We also reviewed ten patient records and

observed daily activity and clinical practice within the department. Prior to and following our inspection we analysed information about the service which was provided by the trust.

Summary of findings

In our previous inspection in July 2014 report, we gave Urgent and Emergency Services an overall rating of 'Good'. Following this inspection, we have changed this rating to 'Requires Improvement'. This was because:

- The entrance and exit from the paediatric waiting area opened automatically onto a thoroughfare for vehicles, allowing children to exit potentially unnoticed.
- Although medicines and controlled drugs were stored correctly in the emergency department (ED), we found intravenous fluids were not stored securely in the emergency medical decision unit (EMDU). We also found temperature ranges for fridges storing medicines at low temperature were not always checked in the EMDU and where they were found to be out of range action to address the issue was not taken.
- Compliance with staff training was low with only 42% of doctors and nurses compliant overall.
- Not all medical staff were aware of the need to obtain senior clinical review prior to discharging certain high risk patients such as those suffering chest pain.
- Whilst local guidance was in place and accessible, we found that review and update processes were not robust and some guidance appeared to be several years out of date.
- Although the department took part in national audit programmes, we saw little evidence of action to address poor results. Instead staff relied on incidents of poor practice to help them identify required action.
- We noticed that patients brought to the department by ambulance sometimes had to wait in a corridor which impacted on their privacy and dignity. Staff tried to minimise the impact by creating as much space as possible between these patients.
- Despite making attempts to manage the flow of patients through the department, targets for providing care and treatment in a timely way were consistently not being met.
- Although leaflets were available which provided information for people following discharge from the

Urgent and emergency services

ED, none of these were displayed in languages other than English. When we asked staff about this they were unsure how to obtain leaflets in other languages.
- Although risk registers were in place, these did not include enough information and were not specific to the ED. Some risks such as issues with meeting national targets were not included.
- Closed circuit television (CCTV) was in use but we saw no evidence of signage to warn people about this.
- Governance was in place in the department but this was not robust. For example, data was collected centrally but not broken down specifically to departmental level. This left us concerned that staff were unaware of basic governance matters such as overall cleanliness or record quality.

However:

- There was an open, no-blame culture.
- Staffing was adequate for both medical and nursing staff.
- Areas were visibly clean and tidy with cleaning staff available 24 hours a day to ensure areas were cleaned, decontaminated and available for use as soon as possible.
- Despite our findings in relation to the requirement for senior clinical review for some patients, other risks to patients were managed through triage, rapid assessment, escalation of deterioration and post discharge reviews.
- Safeguarding was managed centrally; with useful flow charts and support from lead nurses should staff have any queries.
- Guidelines were based on national guidance, pain was monitored and pain relief was available if required.
- A range of food and refreshments were available for patients and loved ones visiting the department.
- Staff competencies were maintained using information sharing and teaching. Revalidation was monitored regularly.
- ED staff worked with a range of staff from different teams both within the hospital and externally to ensure a multi-disciplinary approach to care. Services were available throughout the week and staff had access to all the information they required to provide care for patents.
- Staff were aware of the need for consent and assessment of patients lacking capacity. They documented capacity assessments and made decisions based on patient best interests for those unable to provide consent.
- Patients told us the care they received was 'great' and that staff were 'lovely'.
- Patients completed surveys which showed 73% would recommend the service to friends and family members. In another survey 100% of 31 people surveyed said they were happy with the care provided.
- In the CQC Accident and Emergency Survey 2014, patients said they were given enough time to discuss their problems with staff, had confidence in staff, felt they could summon staff if needed and felt involved in their own care. They also felt staff gave them enough privacy and dignity.
- We saw staff caring for patients in a kind and empathetic manner, providing blankets to ensure they were comfortable.
- Staff were familiar with the needs of local people. Telephone translation and web based video sign language translation were available for patients whose first language was not English or who had hearing problems, a wide range of chaplaincy services were available and services for patients living with dementia were also provided.
- Complaints were managed through an established process with changes made to improve services where possible and information circulated to staff.
- The culture was positive, and we saw that staff at all levels formed a cohesive team built on peer support and dedication.
- Leaders engaged with staff at all levels and helped during busy periods.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

In our previous inspection in July 2014 we rated safe as good and following this inspection we have changed this rating to requires improvement. This was because:

- Although there was a system in place for reporting incidents, we found evidence that some incidents were not reported that should have been.
- The entrance and exit from the paediatric waiting area opened automatically onto a thoroughfare for vehicles, allowing children to exit potentially unnoticed. This had not been reported formally via the reporting system or listed on a risk register.
- Although medicines and controlled drugs were stored correctly in the ED, we found intravenous fluids were not stored securely in the Emergency Medical Decision Unit (EMDU). We also found temperature ranges for fridges storing medicines at low temperature were not always checked in the EMDU and where they were found to be out of range action to address the issue was not taken.
- Compliance with staff training was low with only 42% of doctors and nurses compliant overall.
- Not all medical staff were aware of the need to obtain senior clinical review prior to discharging certain high risk patients such as those suffering chest pain.

However:

- Staffing was adequate for both medical and nursing staff. Nurse agency use and sickness rates were very low.
- Areas were visibly clean and tidy with cleaning staff available 24 hours a day to ensure areas were cleaned, decontaminated and available for use as soon as possible.
- Safeguarding was managed centrally; with useful flow charts and support from lead nurses should staff have any queries.

Incidents

- There was a culture of reporting and learning from incidents amongst staff in the department. Nurses said they were encouraged to report incidents, describing the culture as 'open' and 'non-blame'. However, not all incidents were reported by staff that should have been. For example, reception staff told us they had experienced occasions when children were able to open the automatic doors in the paediatric waiting area which led to a road, but we saw no evidence this had been reported.
- When incidents were reported electronically, staff received receipts and could request feedback following investigation.
- Between April and July 2016, the department reported 233 incidents, 224 of which were reported as low or no harm. Of the remaining incidents, three resulted in death (two related to insufficient response to the change in a patient's condition), and six related to moderate or severe harm (including injury to staff, a medication issue and assault).
- Managers told us that root cause analysis was done following certain incidents and that debriefs took place if required.
- Lessons learned following incidents was provided via supervisors, in newsletters, monthly staff and directorate meetings or with individual staff members.
- Practice was changed following serious incidents. For example, staff changed the criteria for senior clinical reviews of children prior to discharge following a serious incident involving a child.
- Mortality and morbidity meetings were held monthly. Consultants, nurses and physiotherapists were invited to attend. Here staff discussed both good and poor practice to aid improvement.
- Medical and nursing staff who we spoke with were aware of the Duty of Candour. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw evidence that consideration of Duty of Candour principles were included in incident reports and investigations whereby staff had to confirm whether the process had been implemented when reporting incidents.

Cleanliness, infection control and hygiene

- All the areas we inspected were visibly clean and tidy, including reception and waiting areas, triage rooms, treatment bays and corridors.
- Cleaning staff worked 24 hours a day, seven days a week in the department, completing scheduled tasks such as cleaning bays, toilets, corridors and examination or

treatment rooms. Completed tasks were recorded each day. Records from June 2016 showed these were fully completed. There was room for staff to record extra comments such as recording outstanding tasks at the end of a shift.
- Schedules included measures to reduce the risk of Legionella disease infecting water supplies. We saw entries for September 2016 (up to 26 September) were completed correctly.
- Staff were available via radio for individual cleaning or disinfecting requests following patient care.
- The trust completed cleaning audits including details about hand hygiene and mattress cleanliness. However the results provided by the trust included all wards and directorates, with no details about sample sizes for checks in the ED. Nevertheless, the results showed that in April 2016, 99% of mattresses passed checks against a target of 100% and staff scored 98% for hand hygiene against a target of 95%. In May 2016, the figures were 99% for hand hygiene and 96% for mattress cleanliness and in June; 98% for hand hygiene and 93% for mattress cleanliness. As we were unable to obtain findings specific to the ED we remained concerned that staff in the department had no way of assessing their own levels of hygiene and cleanliness.

Environment and equipment

- In our previous report and during this inspection we saw there was limited space in the department. Staff described this as a challenge. However, plans were in place to expand the resuscitation area to include six bays instead of four by extending the boundaries of the department by December 2016.
- Waiting areas for adults and children were light and airy with ample seating. Magazines were available in the adult waiting area and in the children's area there were toys and a television. There were no wall decorations in the children's waiting area; however, these were present in designated children's resuscitation and majors bays.
- The entrance to the paediatric waiting area opened and closed automatically. Directly outside the doors was a main thoroughfare for buses, cars and ambulances. We were concerned about the risk of children exiting the area unnoticed. Staff said they had experienced small children opening the doors automatically. However the issue was not listed on a risk register.
- The department had a dedicated computerised tomography (CT) scanner and x-ray room, with additional portable x-ray equipment for immobile patients. There was also a plaster room for treating limb injuries.
- During our previous inspection, we noted that the relative's room was small with dim lighting. Whilst the room now had enough chairs for a family to sit, the dim lights were still in use. However a senior manager told us this was being refurbished with completion planned for December 2016.
- There was a room assigned for patients with mental health needs. The room had dual exits, one of which was alarmed if the door was opened. The exits were monitored remotely by security staff in an office in the department. Managers confirmed the room had been risk assessed to help minimise risks to mental health patients. However the trust did not provide us with a copy of this despite being asked.
- We checked a range of medical equipment in the department including paediatric items and devices such as syringe drivers (used to administer medicine for a sustained period of time) and monitors. All the items we checked were within expiry and identified portable electrical appliance testing dates.

Medicines

- A range of medicines and controlled drugs (prescription medicines which are controlled under legislation) were stored in both the emergency department (ED) and the emergency medical decisions unit (EMDU).
- Medicines or controlled drugs were dispensed by medical staff, nurse prescribers (nurses authorised to prescribe) or other nurses using Patient Group Directives (PGDs). PGDs are written instructions which allow specified healthcare professionals to supply or administer particular medicines when prescriptions are not available.
- Trust pharmacy staff attended the departments each day to re-stock medicines.
- During office hours, patients took prescriptions to the on-site pharmacy near main reception. Out of hours, some medicines were dispensed directly from the department or with the support of on call pharmacists.
- We checked a range of medicines and controlled drugs in both departments. Controlled drug stocks were checked daily and documented correctly.

- Drug boxes stored medicines to treat particular conditions such as anaphylaxis (severe allergic reaction) and for intubation, and allowed rapid access. These were appropriately sealed. However in the EMDU we saw that intravenous fluids were not locked away. The Royal Pharmaceutical Society recommends fluids are stored securely (2005).
- Medicines requiring storage at low temperature were stored in fridges and were within expiry date. We saw that fridge temperatures were checked daily in the ED but not always in the EMDU. For example between 1 and 27 September 2016 checks were not documented on four days.
- Where fridge temperature checks were documented in the EMDU between 7 and 10 September 2016, the range exceeded national guidance recommendations of between 2 and 8 degrees Celsius (temperatures of between 11.1 and 1.2 degrees Celsius documented). Furthermore, we saw that documented action to rectify the issue had not been completed.

Records

- Patient records were paper based before being scanned onto an electronic patient information system.
- Consultants told us the electronic system rarely failed but that when it did tasks such as ordering x-rays were done using paper forms, with results passed by telephone.
- Records were audited each month. The results showed that on average between August 2014 and August 2016, 95.5% of records included information about pain, 99.5% included information about a patient's medication, 90% included information about tissue viability and 95% included information relating to use of the national early warning score. We were unable to clarify the exact detail captured during these audits or any formal action taken to improve practice because despite asking for this, the trust did not provide it.
- We reviewed ten records of patients who attended the ED. These were legible and included appropriate details including time of attendance, triage, medical history such as allergies, triage category and reason for attendance.
- Despite this, we also found some important information was missing from three records. In records relating to a child with known safeguarding risks at home, we found no details to confirm that a medical review or referral to a safeguarding team had been completed. The child's date of birth had also been recorded incorrectly, leading to confusion when sourcing further information. In another record we found no evidence of initial treatment for a limb injury (such as immobilisation of the limb) and no record of advice given to the patient either. In a third record, despite finding details of an initial plan, we found no documentation about the actual care provided.
- We also discussed documentation standards with senior managers. They confirmed that documentation was audited centrally each month but they shared our concerns that documentation was not always completed correctly. To try to address this coordinators reviewed records in real time (when patients were still in the department). Where omissions were identified staff were spoken to and issues addressed straight away. Coordinators confirmed this was done daily if activity allowed.

Safeguarding

- The department had a lead consultant for safeguarding and staff had access to the trust safeguarding team available during office hours or a link nurse (someone who staff can approach for specialist advice).
- Flow charts were used to help staff provide the right care for vulnerable children and adults and refer concerning cases to other agencies appropriately. These were displayed in the department and contained clear instructions for staff to follow and instructions for notifying agencies, particularly for children.
- There was also a training programme and process in place to support staff caring for vulnerable children and adults.
- Training was mandatory with a compliance target of 75%. Staff completed one of three levels of training based on the level of contact with patients. Nurses completed level two and senior nurses completed level three training which was in line with NHS England guidance.
- However, the figures for completed training were low. Only 59% of nurses had completed level two and 45% of senior nurses had completed level three training, both of which were below the target of 75%. Staff responsible for training explained that the figures were inaccurate due to changes to where staff worked (following the change of Chorley ED to a UCC). Efforts were being made

to rectify this and place staff onto training programmes where required. We saw weekly communication with course providers to identify spare places for staff and a number were scheduled to attend in coming weeks.
- Female Genital Mutilation (FGM) was covered in training and discussed at monthly safeguarding meetings.
- The monthly safeguarding meetings discussed a range of topics including details of recent referrals (including outcome), local processes, child sexual exploitation, domestic violence and training. Staff from other organisations such as social services were invited for the purposes of information sharing but had only attended once in six months. Other attendance was poor. For example out of 27 people invited to meetings between January and June 2016; only eight attended in April, and six attended in May and July. No attendees were recorded for March or June and in February no meeting took place. The highest number of attendees (15) were in January.
- A noticeboard in the department displayed information about contact details for reporting concerns or seeking advice as well as information leaflets and pathways for reporting concerns both within and outside of office hours.
- Information systems in the department allowed staff to record details about safeguarding for particular patients, including previous attendances. However, details had to be accessed in a separate folder in the department computer system rather than on the patient record itself. We reviewed the process for one patient and saw that the details did not correspond. We were concerned that using two separate systems may increase the risk of details being mixed up.
- Where we found details of safeguarding concerns missing in one child's record, we escalated our concerns to a consultant and senior nurse who immediately investigated and took action to address the problem.

Mandatory training

- Staff completed core training modules covering topics including; fire safety, fraud awareness and bribery awareness. Clinical staff completed additional training topics relevant to their roles.
- Training was delivered either face to face by trainers, or through e-learning on the trust intranet.
- The trust had various targets for the percentage of staff who should be compliant (up to date) with training. For example, the target for core information governance was 80% and conflict resolution it was 60%.
- Only 42% of medical staff were compliant with training overall which was less than the compliance figure of 66% that we noted during our previous inspection in 2014. Whilst 83% were compliant in fire safety, fraud and bribery awareness training, figures were much lower for other topics. For example, only 27% were compliant with antimicrobial stewardship training, 30% with advanced basic life support, 16% with advanced paediatric life support and 18% with paediatric basic life support.
- For nursing staff, the overall compliance figure was also 42%. Whilst 80% were compliant with fire safety, fraud, bribery awareness and information governance, and 83% were compliant with conflict resolution training; compliance was much lower for other topics. For example, only 28% were trained in basic life support, 36% in advanced life support, 35% in moving and handling techniques and 59% in oral medication training.
- Education staff confirmed that actions were in place to improve low compliance. We saw that life support training was discussed during a staff meeting in July 2016 and further training was in progress. However, this was limited by the number of spaces available. Staff showed us emails which confirmed they checked for spaces on a weekly basis to ensure staff attended as soon as possible.

Assessing and responding to patient risk

- Processes were in place to manage potential risks to patients by prioritising the order in which care was provided. These included taking a brief medical history and baseline clinical observations (abnormal observations can indicate early deterioration in a patient's condition). The Manchester Triage System (MTS) and Early Warning Score (EWS) systems were also used. The MTS is a clinical risk management tool used worldwide to prioritise patients based on how unwell they are and how quickly they need to be seen using categories green, yellow, orange and red. EWS systems analyse clinical observations within set parameters to

determine how unwell a patient may be. When observations fall outside parameters they produce a higher score, requiring more urgent clinical care than others.

- All patients attending the ED were triaged using MTS. We observed the process where medical history and safeguarding issues were discussed and initial treatment provided where necessary. Some triage categories were automatically assigned due to the increased risks associated with certain conditions. For example, patients with a body temperature higher than 38 degrees Celsius were placed in an amber category.
- Nursing staff told us that certain conditions including possible sepsis were escalated to medical staff during initial assessment to avoid the risk of unnecessary deterioration in patients. We saw evidence of this in practice.
- Patients attending by ambulance were triaged using a rapid assessment and treatment model (RAT). This was predominantly nurse led but consultants assisted when staffing allowed (approximately four hours each day).
- Prior to initial assessment, reception staff escalated certain ambulatory patients arriving in the ED with symptoms which posed more risk than others. These included patients with chest pain, severe pain or severe allergic reactions. Staff told us these were formalised in trust guidance but were unable to locate this when we asked to see it. However, when a patient arrived at reception in acute pain, we saw staff escalate his arrival to nurses efficiently.
- Patients were cared for in particular areas to reduce the risks associated with an ED environment. For example, mental health patients were, where possible, assigned to a particular bay which was close to the nurses' station and had been risk assessed. However, despite asking for a copy of this risk assessment the trust did not provide it.
- Adult and paediatric waiting areas were visible to reception staff which helped them to identify deteriorating patients quickly and summon help via an emergency button.
- Patients referred to the EDMU did so only under strict criteria such as being able to sit or expected to go home following test results. This helped reduce risks given that these patients were under less observation than in the main ED.
- In line with Royal College of Emergency Medicine (RCEM) standards, the department worked to reduce the risk of incorrectly discharging patients by ensuring only senior doctors authorised the discharge of certain patients, for example, those with chest pain, repeat attenders within 72 hours or febrile children under a year old. However two doctors we spoke with were not aware of this requirement. When asked, one told us 'if I'm confident there is no sinister cause, I will not discuss it [with a senior doctor]' and also said there was no formal arrangement in place for seeking senior review for repeat attendance within 72 hours. Another told us they did not seek senior review for patients with chest pain prior to discharge. Despite this, doctors were aware of the need to seek senior review prior to discharging children. This was because the department had changed their practice following the death of a child who was discharged from the department. We saw that reminders were issued to staff in newsletters but we were concerned there was no formal assurance that staff were aware of the discharge process.
- To reduce the risks of deteriorating babies and children, staff trained in paediatric life support techniques. Nurses told us they underwent paediatric life support training and consultants and middle grade doctors trained in advanced paediatric life support (APLS) techniques. However, data provided by the trust showed that training compliance was low. This left us concerned that not enough staff could offer intermediate or advanced care for these children should it be required. Additionally, we saw no evidence that this was identified as a possible risk such as inclusion on a risk register or any action plan.
- The department worked to minimise the time taken for ambulance staff to handover patients by ensuring reception staff mobilised to the corridor to check patients in as soon as they arrived and also validated all the timings relating to handovers. However, any delays that did occur were recorded. This showed that between August 2015 and July 2016, 1167 delays over 60 minutes occurred. The frequency of delays varied between each month, but were highest in May 2016 (201) and July 2016 (192), and lowest in August (18) and September 2015 (15).
- Following attendance, consultants reviewed records of certain patients to ensure the care provided was correct. This included any patients triaged as amber or suffering chest pain who had not been admitted to hospital.
- Staff monitored the time taken to initially assess patients, which should be within 15 minutes of arrival.

Between March and September 2016 the average time taken was nine minutes. The time average taken was lowest in April (five minutes) and highest in August (14 mnutes).

Nursing staffing

- A range of 44 nurses (including staff nurses, sisters, matrons and nurse clinicians) worked in the ED to provide care for patients.
- Nurses told us that rotas were planned so that ten nurses worked during the day and up to eight at night time. Up to two healthcare assistants (HCAs) also worked in the department during the day and one at night time with seven employed in total.
- We reviewed rotas between June and August 2016 to confirm what we were told. These showed that on eight occasions there were only seven nurses working during the day (until the afternoon when additional staff joined the team). There were 28 occasions when only eight nurses were working until staff joined them in the afternoon. Despite this, senior nurses assured us that staffing levels were appropriate. They told us that a senior staff member in the trust had written a report about staffing in the ED but when we asked for this the trust could not provide it. We were therefore unable to corroborate the assurances provided by ED staff.
- There were 3.5 whole time equivalent nurse vacancies in the ED at the time of our inspection with recruitment opportunities advertised. Senior managers confirmed that no formal acuity tools were used to accurately calculate the number of nurses required to provide care for patients. Instead, in April 2016, senior nurses made formal professional judgements based on national guidance. From this, managers determined that staffing was appropriate and they felt able to safely staff the department. We asked for written evidence of staffing levels to corroborate what we were told but the trust did not provide this.
- Nurses were assigned to areas in an organised way. For example, nurse clinicians (senior nurses) cared predominantly for patients in the 'majors' area. Nurse coordinators were assigned to each shift on a supernumerary basis following recommendations made after an external review in October 2015.
- Senior managers and nurse coordinators told us agency staff were rarely used. We asked the trust to provide the percentage of agency and bank staff used. However they did not supply this information.
- Nurses told us there were not always enough nurse clinicians to cover every shift. They showed us rotas where on four days out of 25 there were no nurse clinicians available to cover required shifts. Managers explained that this was not the case but that two clinicians were in training posts.
- Senior staff explained that staffing levels had improved after the trust's other ED based at Chorley Hospital was changed temporarily to an urgent care centre in April 2016. This allowed nurses to transfer to the Royal Preston Hospital which boosted staffing levels.
- Nursing handovers took place each morning and lunchtime when new staff arrived in the department. We observed one handover at 12:15pm, facilitated by two nurse coordinators and attended by nurses and a consultant. Details were shared about each patient, including the reason for attendance and plans for care or treatment. The consultant contributed further details. We noted that although details about patients were discussed, no discussion took place about staffing levels or other departmental challenges.
- Regular meetings for nurses took place, including monthly or six weekly 'sisters' meetings.
- Staff sickness rates were low. Between April 2015 and March 2016, the sickness rate for nurses was 2.37% and 0.62% for healthcare assistants which was below the average for NHS staff across England (4.2% March 2016).This helped minimise the use of agency nurses.

Medical staffing

- The department employed 6.6 trainee doctors (years three to six of training), 10.6 middle-grade doctors and 12.6 consultants (whole time equivalent). However, two middle grade doctors were absent and not expected to return to work. This meant there were only 8.6 working middle grade doctors available. This equated to 9% higher number of consultants than the average for other EDs in England, 4% higher middle grade doctors and a similar number of trainee doctors. Consultants were present between 8am and midnight each day.
- Medical rotas showed that two or three consultants worked until 9pm, with one consultant generally available between 9pm and midnight. Between midnight and 8am, a consultant was available on an on-call basis, with two middle grade and three junior doctors present in the department. One physician associate worked in the department. Physician

associates support doctors in the diagnosis and management of patients by taking medical histories, ordering tests and analysing results under direct supervision of doctors.

- Doctors employed in the department had been responsible for staffing the trust's other ED based at Chorley. However in August 2016 the decision had been made that there were not enough doctors between these two sites, which resulted in the Chorley ED being changed to an urgent care centre which operated during daytime hours only. This change therefore led to a higher level of medical staffing at this ED.
- Having multiple consultants in the department each day allowed one consultant to focus on teaching and review care provided the previous day to ensure it was correct.
- Medical handovers took place at 8am each morning. Here, doctors handed over details of each patient in the department as well as any deaths or incidents in the department overnight. Other verbal handovers took place at the beginning and end of each shift. Doctors also attended the nursing handover at 12:15pm each day. Here a senior consultant contributed additional clinical detail about patients being discussed.
- Despite requesting data for sickness rates for medical staff the trust did not provide it.

Major incident awareness and training

- The trust had a range of plans in place to support staff should there be a major incident or business continuity issues. These included an overarching business continuity plan and individual plans for pandemics, adverse weather, fuel shortages or information system failures. However, we noted that these were not all up to date. For example, the business continuity plan was published in 2014 but had breached the review date of May 2016.
- Simulation exercises enabled staff to test their response to incidents. The last simulation exercise centred on decontamination in August 2016. Previous exercises had taken place to simulate caring for patients with Ebola. Ebola is an infectious and generally fatal disease marked by fever and severe internal bleeding which originated in Africa.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

In the previous report we did not have sufficient evidence to rate this domain. However following this inspection we have rated it as requires improvement. This was because:

- Whilst local guidance was in place and accessible, we found that review and update processes were not robust and dates on some guidance were several years out of date.
- Although the department took part in national audit programmes, we saw little evidence of action to address poor results which were evident in the majority of those undertaken. There were no action plans to address problems or improve performance. Instead staff relied on incidents of poor practice to identify poor practice.
- Whilst staff told us that local audits were undertaken to monitor practice in areas such as use of care pathways, we found that other audits such as record keeping or sepsis care were not focused solely on the ED which made it difficult to monitor performance specifically in the ED
- Low numbers of nurses had received their annual appraisals this year.

However:

- Guidelines were based on national guidance
- Pain was monitored and a range of pain relief was available should it be required.
- A range of food and refreshments were available for patients and loved ones visiting the department.
- Staff competencies were maintained using information sharing and teaching. Revalidation was monitored regularly.
- Emergency department (ED) staff worked with a range of staff from different teams both within the hospital and externally to ensure a multi-disciplinary approach to care.
- Services were available throughout the week and staff had access to all the information they required to provide care for patents.

- Staff were aware of the need for consent and assessment of patients lacking capacity. They documented capacity assessments and made decisions based on patient best interests for those unable to provide consent.

Evidence-based care and treatment

- Evidence based care and treatment was provided, using national guidelines formulated by the National Institute of Health and Care Excellence (NICE), the Royal College of Emergency Medicine (RCEM), National Poisons Information Service (ToxBase) and the Resuscitation Council UK.
- National guidelines formed the basis of local policies and pathways for treating conditions such as paracetamol overdose (using guidance from the National Poisons Information Service).
- Both national and local guidelines were accessible via the trust intranet systems. They covered clinical care and treatment, referral to other places of care and equipment use. Nurses told us that when new guidelines or pathways were introduced, information was shared to ensure all staff were made aware. For example, following the introduction of a new pathway for treating alcohol related liver disease, specialist nurses attended the department to speak with staff and information was also shared at staff meetings.
- Senior medical staff told us guidelines about taking clinical observations in children were reviewed and updated regularly. However other evidence we found did not support this. For example, whilst consultants assured us the guideline for renal colic had been reviewed recently, the latest review date was 2011. The review date for the guideline for assessing patients with cardiac chest pain had expired in April 2015 and there was no review date on guidance for acute coronary syndrome. This left us concerned that guidance was not reviewed as often as it should be which posed a risk that staff were relying on guidance which was outdated.
- Some local audits were done to confirm assurance about certain guidelines or pathways but when we asked to see results these were not available. We were told these could be sourced from the trust but when we asked the trust could not provide them. This posed a risk that staff were not aware of their own performance in relation to important pathways of care such as sepsis.
- The only local audit that we were able to locate results for was use of the pathway to treat renal colic ((April 2016) Results showed that more than half of patients were managed as outpatients which helped reduce unnecessary admissions. For patients attending for scans at a later date rather than at the time of their initial visit, the audit found no increased complications or unplanned returns. This showed that the guidelines were effective for patients and remained fit for use.

Pain relief

- Pain was assessed using a scoring system with zero indicating no pain and ten indicating significant pain. This helped staff quantitatively measure pain levels and assess how best to relieve it.
- Pain in children was scored using a pictorial chart, with a smiling face indicating no pain and a sad face indicating pain was present.
- Pain relief such as paracetamol, co-codamol or ibuprofen was provided by nurses during initial assessment, if necessary, using Patient Group Directives (PGDs). PGDs are written instructions which allow specified healthcare professionals to supply or administer particular medicines when prescriptions are not available. Other pain relief could be requested from nurse clinicians who were trained to prescribe, or medical staff.
- In the CQC Accident and Emergency (A&E) patient survey 2014, which reviewed emergency care across both the trust's emergency and urgent care departments, patient's gave a score of seven out of ten for getting pain relief quickly after requesting it, and eight out of ten for feeling staff did everything they could to control pain. These scores were about the same as other trusts surveyed in England.

Nutrition and hydration

- A housekeeper and volunteers in the ED worked to ensure patients and loved ones were offered food and drinks where appropriate.
- Hot breakfasts and lunches were provided during the day, with soup and sandwiches provided at night.
- Clinical staff identified patients able to eat and drink on a whiteboard. This reduced the risk of nil by mouth patients being given food or refreshments incorrectly.
- Water was available in the reception area, but there were no signs reminding patients not to eat or drink prior to assessment.
- In the CQC accident and emergency patient survey 2014, the trust (including the ED at Preston and the urgent

care centre at Chorley) scored seven out of ten for providing suitable food and drinks for patients in the department. This was about the same as other trusts surveyed in England.

Patient outcomes

- The department took part in mandatory national audits run every three years by the Royal College of Emergency Medicine (RCEM). The latest audits included: Asthma in Children (2013/14), Paracetamol Overdose (2013/14), Initial Management of the Fitting Child (2014/15), Mental Health in the ED (2014/15) and Assessing for Cognitive Impairment in Older People (2014/15).
- The audit for asthma in children found that out of 50 children, staff only documented pulse, systolic blood pressure and temperature in 8% of cases within 15 minutes (blood pressure was worse than the national average of 10%), and a peak flow reading within 15 minutes in only 2% of cases against targets of 100% (also worse than the England average of 10%). Treatments of intravenous hydrocortisone or oral prednisone were only provided in 48% of cases against a target of 100% (worse than the England average which was 66%).
- The audit for paracetamol overdose found that out of 46 cases, no patients received N-acetylcysteine within one hour of arrival and 54% of patients received recommended treatment (worse than the England average).
- Results for the initial management of fitting children were comparable to the England average with staff recording presumed aetiologies in all of the 43 cases surveyed. They were better than the England average (96%) for recording eye witness histories (100%).
- In the audit of mental health in the ED, the department was better than the England average for completing a risk assessment (94% against an England average of 72%), taking a history of previous mental health issues (94% against an England average of 82%) and assessing patients for dependency to alcohol or illicit substances (68% with no target against an England average of 40%). However, they were comparable with the England average in relation to mental health practitioners assessing patients within one hour (England average of 0%). This had not been done in any of the 50 cases reviewed in this hospital or across England.
- For assessing cognitive impairment in older people, none of the 80 cases reviewed showed that cognitive assessments had taken place (worse than the England average of 11%) or that assessment findings had been communicated to carers (comparable to the England average of 0%).
- Consultants told us outcomes for sepsis care were monitored by a central team within the trust. However, when we asked for specific figures for the ED, the trust were unable to provide them. This left us concerned that ED staff had no way of knowing how effectively they were at identifying and treating this condition.
- Managers confirmed there were no specific action plans in place to address issues identified in audits. Managers told us that, despite some poor results, they felt assured that the care provided was good. Instead of relying on audit outcomes, they based their judgement on the belief that local clinical guidelines were good and that low levels of incidents relating to the audited elements of care were received. We remained concerned that indicators for the quality of care which benchmarked the department nationally were not being considered as thoroughly as they should be.
- Although the department was a major trauma centre, it was not compliant with the full range of major trauma national quality indicators. For example, one indicator recommends trauma team attendance to the department within five minutes of being notified. Managers agreed that when consultants (trauma leads) were only available on call during the night, this was not possible. Instead staff confirmed they relied on telephone advice from the trauma lead or attendance as soon as possible.
- The trust monitored unplanned re-attendance to the ED within seven days of discharge. Between March and August 2016, 6.6% of patients re-attended the department which was generally better than the England average over this period (between 7% and 8%).

Competent staff

- A practice educator worked to facilitate training for ED staff. One consultant was assigned to teach medical staff three to four times weekly.
- Noticeboards provided specific details for staff such as student support and revalidation. Details included event timetables, contact details for mentors and advice.
- A process was in place to help ensure staff received an annual appraisal with their manager. At the time of our inspection, only 78% of administrative staff, 55% of nursing staff and 77% of medical staff had received their

annual appraisal which was worse than the trust target of 85%. However, staff responsible for monitoring appraisals told us that the trajectory for completion ran until April 2017 and the expectation was that all staff would be up to date by that time.
- Revalidation was monitored centrally and department leads received a list of those approaching the point of revalidation each quarter. Staff involved in the process told us that some nurses had already been through revalidation with no problems reported.
- Teaching sessions were delivered for staff covering a range of topics such as sepsis awareness.
- In light of the department being a designated trauma centre, trauma training was provided which included training to manage paediatric or young adult major trauma care.
- Competencies for the use of Patient Group Directives (PGDs) were reviewed every two years to reflect new guidance.
- In addition to mandatory training, extra training was provided in areas such as sepsis.

Multidisciplinary working

- Teams from specialties including anaesthetics, orthopaedics, surgery, radiography and nursing worked together, especially when providing major trauma care.
- Clinical staff worked collaboratively within regional paediatric and trauma networks and within a national network of trauma nurses to take part in peer discussion and provide consistent care.
- ED and security staff worked closely together and linked with local police to ensure staff and visitors were kept safe.
- Clinical staff worked closely with nurses and doctors specialising in stroke care who attended the ED upon request. Staff linked with regional on call teams via telemedicine for out of hours queries (using a web based visual link between a specialist doctor and the patient).
- Nurses described working closely with the Hospital Alcohol Liaison Service (HALS) and the Proactive Elderly Care Team (PECT). The PECT included geriatricians, physiotherapists and occupational therapists that assessed mobility, aid requirements or onward support for elderly patients. The HAL included specialist nurses providing assessment, interventions and advice to patients, family, caregivers and staff about alcohol-use. ED nurses told us both teams were responsive to the needs of patients.
- The department was supported by the trust bereavement team who were contactable via the hospital bleep system.
- ED staff met regularly (every three months) with staff from the paediatric department to share information and maintain good working relationships. Nurses described paediatric staff as responsive and helpful when they had queries.
- Staff also worked closely with mental health nurses and approved mental health professionals from a local NHS trust to provide care and support for mental health patients.

Seven-day services

- The ED was open 24 hours a day, seven days a week, 365 days a year to provide care for patients.
- The Proactive Elderly Care Team (PECT) was available between 8:30am and 4:30pm, seven days a week.
- The trust bereavement team worked seven days a week (including bank holidays) between 9am and 5pm and chaplaincy services were available 24 hours a day, seven days a week.
- A dedicated X-ray room for ED patients was open between 8am and midnight each day. Other X-ray rooms were available after this time. A radiographer and radiologist were available 24 hours a day, seven days a week.

Access to information

- All the staff we spoke with (including reception staff, nurses and doctors) said they had access to the information they needed to care for patients.
- Information about patients including previous visits, referrals, safeguarding concerns or particular clinical needs were all available via the trust patient management system.
- Doctors said test results came though quickly, with very occasional delays for radiology results at night due to fewer staff.
- Link nurses specialising in particular topics such as mental health and sepsis worked in the department. Link nurses act as a point of contact, sharing information between specialist teams and nurses in the clinical area.

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff worked in line with the principle of implied consent (consent implied by way of actions) when caring for patients able to make decisions. For those unable to make decisions about their care (for example, unconscious patients) decisions were made in line with best interests.
- For patients receiving care under the Mental Health Act, mental health liaison nurses worked on site to provide care 24 hours a day seven days a week. Staff also liaised with a local mental healthcare NHS trust that undertook assessments and initiated care plans for patients if necessary.
- Nurses felt supported by mental health staff but experienced delays sourcing specialist staff such as approved mental health professionals (AMHPs). This placed extra pressure on ED staff because patients stayed in the department for longer, which staff felt was not a suitable environment for them.
- We reviewed the record of one patient who lacked mental capacity. Here we saw evidence that capacity was appropriately assessed and recorded in the notes. Nurses told us that mental capacity assessments were always carried out.
- Staff used a template form to ensure the right details about patients were gathered, including names of people informed of the patient's attendance and the risk of harm.

Are urgent and emergency services caring?

Good

At the previous inspection in July 2014 we rated caring as good, following this inspection the rating remains good, this was because:

- Patients told us the care they received was 'great' and that staff were 'lovely'.
- Patients completed surveys which showed 73% would recommend the service to friends and family members. In another survey, 100% of 31 people surveyed said they were happy with the care provided.
- In the CQC Accident and Emergency Survey 2014, patients said they were given enough time to discuss their problems with staff, had confidence in staff, felt they could summon staff if needed and felt involved in their own care. They also felt staff gave them enough privacy and dignity.
- We saw staff caring for patients in a kind and empathetic manner, providing blankets to ensure they were comfortable.

However:

- We noticed that patients brought to the department by ambulance sometimes had to wait in a corridor which impacted upon their privacy and dignity. Staff tried to minimise the impact by creating as much space as possible between these patients.

Compassionate care

- The trust asked patients to rate their experience of the emergency department (ED) in the NHS Friends and Family test. Between June and August 2016, an average of 73% of patients said they would recommend the service to friends and family members which was slightly below the England average of between 85% and 90%. The average response rate was 15%.
- We spoke to five patients and visitors in the waiting area. They told us they were happy with the care provided and described the nurses as 'great' and 'lovely considering the pressure they are under'.
- We saw that staff had wrapped up an elderly lady in blankets to keep her warm whilst she waited for treatment.
- In June 2016, Healthwatch (an organisation made of staff and volunteers who gather and report the views of local people about health services) visited the department to speak with patients and loved ones about their views. Out of 31 people surveyed, 100% said they were happy with the care received.
- In 2014 the CQC surveyed patients in Emergency Departments across England and provided scores out of ten for certain elements of care. Figures were not provided for this ED alone, but did provide findings for both the trust's emergency departments which were operating at that time.
- In the survey, patients scored the departments nine out of ten for being given enough time to discuss their problem with staff (better than the England average). They also scored nine out of ten for feeling staff listened to them; having confidence and trust in staff, and not feeling staff spoke to each other as if they were not

present. Patients scored eight out of ten for feeling they could summon a member of staff if they needed attention, and for feeling involved in their own care. These scores were all about the same as other trusts surveyed in England.

- In relation to privacy and dignity, patients gave the departments' scores of nine out of ten for treating them with dignity and respect, and giving them enough privacy during examination or treatment. Despite this, we saw that to maintain adequate flow into the department, some patients were assessed in the corridor to avoid delays. We were concerned about the impact on the dignity and privacy needs of these patients and staff shared these concerns. We had highlighted this following our previous inspection in 2014. To minimise this, staff tried to ensure patients were separated as far apart as possible along the corridor.

Understanding and involvement of patients and those close to them

- In the CQC accident and emergency patient survey, patients' scores across both departments were; eight out of ten for feeling staff explained why tests were required, and nine out of ten for feeling staff explained test results in a way they could understand. Both these scores were about the same as other trusts surveyed in England.
- The departments also scored six out of ten (better than the national average) for taking family or home situations into account and nine out of ten for providing enough information about their condition or treatment.
- Overall, patients gave a score of eight out of ten for feeling involved in decisions about care or treatment whilst in the departments which was about the same as other trusts surveyed in England.

Emotional support

- Clinical nurse specialists were available to support patients suffering symptoms of stroke or alcohol misuse.
- The trust chaplaincy service was available 24 hours a day seven days a week to provide spiritual assessment and support for those experiencing loss or feeling isolated in the department.
- Bereavement services were also available every day to support patients nearing the end of life, and their families, as well as helping recently bereaved families of patients who have been cared for in the department.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

In our previous inspection we rated responsive as good and following this inspection we have rated urgent and emergency services as requiring improvement, this was because:

- Despite making attempts to manage the flow of patients through the department, targets for providing care and treatment in a timely way were consistently not being met. The target for patients within 4 hours remained around 85% with a dip to 77% in August 2016. Time to initial assessment ranged from 5 to 14 minutes and time to treatment ranged from 64 to 94 minutes. The total time in the department ranged from 154 to 179 minutes. However the times had not significantly deteriorated following the change to the provision of care at Chorley from an Ed to an UCC.
- Although leaflets were available which provided information for people following discharge from the emergency department (ED), none of these were displayed in languages other than English. When we asked staff about this they were unsure how to obtain leaflets in other languages.
- Despite noting this during the last inspection, the children's resuscitation bay remained unseparated audibly or visually from the other bays. This meant children had to pass adult bays to reach this area.

However:

- Staff were familiar with the needs of local people. Telephone translation and web based video sign language translation were available for patients whose first language was not English or who had hearing problems, a wide range of chaplaincy services were available and services for patients living with dementia were also provided.
- Complaints were managed through an established process with changes made to improve services where possible and information circulated to staff.

Urgent and emergency services

Service planning and delivery to meet the needs of local people

- Staff were familiar with the needs of local people, such as those from European and Asian backgrounds and the languages spoken.
- Waiting areas for adults and children met people's needs with adequate seating and space in the reception area for people to provide details confidentially.
- The department was small in size which caused difficulties accommodating the influx of patients who arrived in the department. Ambulance staff told us the staff experienced difficulties accommodating patients on a daily basis. However, it was hoped that building works to increase the size of areas would improve this.

Meeting people's individual needs

- As a number of patients were elderly, a Proactive Elderly Care Team (PECT) worked specifically to offer support and assist them with specific needs. This helped ensure they could return home as soon as possible.
- The chaplaincy service had access to 32 different religious leaders and there were weekly prayers and services for patients and visitors of Christian and Muslim faiths
- A dementia champion (staff member with a special interest in Dementia) worked in the emergency department (ED) and helped ensure staff were well informed about the condition and how best to provide care for these patients.
- In 2016 the department won an internal quality award for adaptations made for people living with dementia. They also won a dementia research awareness award in 2015, for devising a template form capturing details such as likes and dislikes and how patients express pain, mobilise or take medication.
- Patients living with dementia were identified subtly through the use of a cut out flower shape on their wrist band. This ensured staff could see which patients had needs associated with dementia when providing care.
- Specially knitted gloves and small blankets were available for those living with dementia to use as a comfort aid when in unfamiliar surroundings like the ED. These were provided on an individual basis and replaced each month by a voluntary group.
- Nurses were familiar with 'hospital passports'. These provided hospital staff with important information about patients living with learning disabilities or complex needs and staff told us patients often carried these with them.
- Translation services were available by telephone if required. Face to face translation was also available but advance notice was required which was not always possible given the nature of emergency care.
- The department was piloting the use of webcam sign language interpretation for people with hearing loss. The pilot ran between 9am and 5pm with a view to extending hours in the future. This had begun following issues raised by members of the deaf community who had experienced problems communicating with staff in the department. One nurse also had links with the deaf community, attending regular (weekly or monthly) meetings in the community.
- Staff held contact details of a support group which they provided for young people (under 25 years of age) experiencing drug or alcohol problems and staff from the support group attended the department to see patients if required. .
- Play specialists were available for children should they be required. A play specialist uses an understanding of child development and therapeutic play activities to help children cope with any pain, anxiety or fear they might experience during their time in hospital.
- We noted that the children's resuscitation bay was not separated audibly or visually from the other bays, and that children had to pass adult bays to reach this area. This was highlighted during our previous inspection but the situation remained the same.
- A range of leaflets were available for patients to take home following their visit to the ED. These covered different conditions such as gastroenteritis in children, nose injury and swallowed foreign bodies. The leaflets included contact numbers for patients to use should they have concerns or questions after going home. However we noted that the leaflets were only in English. Nursing staff were not sure how to obtain leaflets in other languages.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. We reviewed data between March and August 2016 which showed the

department consistently failed to meet the target during this period with an average of only 83% of patients meeting the target. The highest was 89% in April 2016 just prior to the change of the trust's other ED to providing urgent care. Immediately after the change in May 2016 the figure fell to 82%. The lowest percentage was 77% in August 2016..

- Other elements of care were also monitored by the trust and reported nationally. These included the average time taken to complete initial assessments, the percentage of patients waiting between four and 12 hours for admission following a decision to admit being made, the total time spent in the department and time taken to provide treatment.
- Between March and August 2016, the average time taken to complete an initial assessment was nine minutes, which was within the national target of 15 minutes. In May 2016 the average monthly assessment time doubled to ten minutes from the previous month (Five minutes in April 2016). The longest average monthly assessment time was 14 minutes in August 2016.
- Between March and August 2016, 61% of patients waited between four and 12 hours from the point of decision to admit and actual admission. Staff told us they did not know of any occasion when patients waited over 12 hours in the department and data provided by the trust confirmed this.
- The total average time patients spent in the department between March and August 2016 was two hours 43 minutes. This was highest in May 2016 with a total average time of two hours, 59 minutes.
- Between March and August 2016, the time taken to provide treatment ranged between 64 and 94 minutes with an average time of 78 minutes. The longest average time taken was in May 2016 (94 minutes)
- When we asked staff about their concerns they described 'exit block' as an issue. This happened when patients could not be treated and moved out of the department quickly enough. Space became limited, leading to patients waiting in corridors. We saw this issue occur throughout our inspection.
- During our previous inspection we told the trust to improve mechanisms for achieving and maintaining performance to meet targets. During this inspection, ambulance staff said although the department often ran at full capacity leading to patients queueing on the corridor, staff were proactive and we saw some mechanisms in place to try to maintain performance.
- To help start the process of care as soon as possible, staff used a rapid assessment and treatment model (RAT) during initial assessment. Predominantly led by nurses, but with consultants when possible; this meant care plans could start upon arrival rather than waiting for an available bay.
- Staff worked to streamline the handover process between ambulance and ED staff. Firstly reception staff accessed a terminal in the corridor during handover, ensuring details were entered promptly. Additionally, reception staff monitored all handover times in excess of 15 minutes, by cross checking them with other documentation and adjusting times where necessary.
- Some patients (approximately 30-40 daily) were referred to a co-located primary care service following triage if their condition did not require emergency care or treatment. Run by the local clinical commissioning group, managers were concerned that a recent change in service provider would impact on flow in the ED. This was because the current contract was due to cease two months prior to the new contract date. At the time of our inspection, the managers were unsure of arrangements to cover this shortfall.
- Patients requiring computerised tomography scans (such as stroke or major trauma patients) experienced minimal delays, with a dedicated scanner situated directly behind the resuscitation area. This made the process of investigation and formulation of care plans more efficient.
- The department used in-house services such as the Hospital Alcohol Liaison Service and Proactive Elderly Care Team who helped care for specific patients. A Hospital Integrated Discharge Team was being introduced with recruitment in progress and two lead therapists already in post.
- Patients no longer requiring active emergency care were moved to an emergency medical decisions unit (EMDU). Here, ambulatory patients could undergo a period of observation or await test results prior to discharge without blocking the ED.
- Building work to increase the number of resuscitation bays available from four to six was due to begin in December 2016.

Urgent and emergency services

- In the wider hospital, bed meetings were held to focus on maintaining flow throughout the hospital. This helped ensure that beds were available for patients to move out of the ED following admission. Senior ED nurses attended these meetings twice daily and told us extra meetings could be arranged if the department was experiencing problems with flow. They described feeling supported by the hospital bed management team.
- Following delays sourcing ambulances to discharge patients after 7pm, senior managers commissioned a private ambulance service at night to help ensure patients ready for discharge were transferred home without delay.
- Despite all of these initiatives, the department still experienced periods where patient numbers exceeded capacity. At 10:05am on one day during our inspection we noted there were 23 patients in the department with space for only 19. Four patients no longer required emergency care but were waiting for available hospital beds.
- Staff told us they regularly experienced occasions where 40 patients were in the department, however on another day we arrived to find 61 patients being cared for. Patients were placed into cubicles, waiting areas, fracture clinic cubicles and corridors. Managers listed the steps taken to manage this which included bringing medical staff from wards coming to identify patients who could be moved out of the ED under their care, moving all consultants to clinical duties, liaising with the hospital bed managers to locate available beds and reviewing options to cancel elective surgery cases to limit the numbers of patients entering the hospital.
- We noted there were no formal procedures to help staff decide when pressures in the department required escalation to senior trust managers. Instead, experienced staff made decisions based on judgement. However managers explained that, following visits to local NHS trusts, a new electronic system would be implemented which would act as a formal escalation tool for staff. In the meantime staff told us shift summary reports were completed three times daily and sent to senior managers including the Chief Executive. This provided information for analysis which helped identify reasons for flow issues. Despite asking for copies of these reports the trust did not provide them.

Learning from complaints and concerns

- Between 1 August 2015 and 31 July 2016, the ED received 33 complaints. Ten related to staff attitude, 17 to clinical care, two were about communication and the remainder were about discharge or transfer arrangements and equipment.
- Advice to help patients and visitors make complaints was available in leaflets or via the trust's Patient Advice and Liaison Service (PALS). Complaints about nursing care were investigated by the Matron and medical care issues were investigated by the consultant on call at the time of the incident.
- One staff member acted as a link for complaints and compliments in the ED. They compiled and monitored trends and supported staff through the process.
- Information about the nature of and outcome of complaints was shared at monthly governance meetings. Compliments were also discussed.
- Nurses confirmed they received feedback following complaints either individually, through written reminders or by completing reflective pieces of work. We saw that following a complaint about overheard conversations at the nurses' station, staff were reminded of the need for discretion and confidentiality. Following a complaint about the lack of sign language facilities, the department introduced a new web-based video sign language service.

Are urgent and emergency services well-led?

Requires improvement

At the previous inspection in July 2014 we rated well led as good, following this inspection we have changed this rating to requires improvement. This was because:

- Although risk registers were in place, these did not include enough information and were not specific to the emergency department (ED). Some risks such as issues with meeting national targets were not included.
- CCTV was in use but we saw no evidence of signage to warn people about this.
- Governance was in place in the department but this was not robust. For example, data was collected centrally

but not broken down specifically to departmental level. This left us concerned that staff were unaware of basic governance matters such as overall cleanliness or record quality.

However:

- The culture was positive, and we saw that staff at all levels formed a cohesive team built on peer support and dedication.
- Leaders engaged with staff at all levels and helped during busy periods.

Vision and strategy for this service

- The trust vision was to be recognised for providing acute and specialist services with high standards of compassionate, safe and research driven, innovative care. We saw the vision formed the approach to care delivery for patients attending the emergency department (ED). Staff recognised the requirements for safe care and we saw their interactions with patients were caring and compassionate. Regular teaching for staff helped meet the vision to provide care that was research driven and innovative.
- Values placed an emphasis on team work and personal responsibility and we saw evidence of these in action throughout our inspection.
- The trust strategy included elements specifically related to the ED. These included improving specialist care and clinical services. Since obtaining major trauma status in 2013, the department had met this aim by installing a computed tomography (CT) scanner to improve diagnosis and treatment for patients.
- Other improvement plans for the ED included building works to expand the department. Due to start in December 2016 and be complete by March 2017, this would lead to two extra resuscitation bays and new rooms for relatives to wait quietly or view a loved one following death.

Governance, risk management and quality measurement

- Whilst meetings were held to discuss governance issues each month, we were less assured that governance was managed effectively in areas such as quality measurement. For example, trust wide and directorate data was collected to measure service performance and quality of care (such as overall cleanliness or sepsis treatment) but the trust could not provide data at departmental level. Instead we were given information about a number of wards and units together. This left us concerned that if service performance or care data in the department was not available, staff may lack awareness of successes, or areas requiring improvement.
- Some but not all risks were managed day to day. For example, there were no protective screens in the reception area although security staff were available and panic buttons were installed. Four mobile panic alarms were available for clinical staff to carry, one of which was assigned to the triage nurse on duty. However, the risk of children exiting the paediatric waiting area through automatic doors was not managed despite staff telling us they had experienced problems with this in the past.
- In addition, we were concerned that the risk register was not readily available and did not contain all of the information required. When requests were made for the risk register, inspectors received several copies, all of which differed. Risks on one version were not included on another. The register was not specific to the ED but instead incorporated risks for the entire division of medicine. Important information such as the date the risk was entered, timelines or mitigative actions were not included. This meant that we were not assured that departmental managers had full and clear oversight of risk. We also found that obvious risks such as failure to meet Department of Health targets specific to emergency care were not included. This risk was not included on the trust risk register either. When we reviewed the trust risk register, we found an item listed there which related to the ED but was not listed on the register for the division of medicine.
- Whilst CCTV was used in waiting areas and monitored by security staff, we saw no signage informing people of this.
- Despite these concerns, governance meetings were held monthly which reassured us that staff worked to discuss and share information. Led by a consultant and minuted, they enabled staff to discuss topics including risk, incidents, complaints, safeguarding, infection control and consent. We saw that actions were generated to ensure information was disseminated to departmental staff.

Urgent and emergency services

Leadership of service

- Consultants felt supported by senior leaders in the organisation particularly when introducing new ideas into practice. They told us they were given the freedom to try new ideas such as introducing senior staff to the initial assessment process.
- Clinical staff knew who trust leaders were. They told us the Chief Executive regularly came to see them during busy periods. Others said they saw senior leaders every week.
- Staff spoke highly of their immediate line managers in the department, telling us that those with clinical backgrounds left their offices and worked in the department during busy periods. One manager had undertaken triage duties recently.

Culture within the service

- Consultants told us they chose to work for the department even though other hospitals were closer to home, citing the patient centred focus and positive atmosphere between colleagues as reasons why. They also described the openly supportive culture where they felt able to seek advice from colleagues, even when they weren't on duty.
- Staff reported that this positive culture ensured staff were committed (demonstrated by low sickness rates) to what was a strong team, managing flow and providing safe, effective and compassionate care for patients. Staff told us they worked with people they could call friends which supported the feeling they belonged to a cohesive, supportive department.
- Staff spoke highly of each other with doctors describing the nurses as 'fantastic' and 'a credit to the hospital'. Nurses told us they received 'incredible' support from senior doctors in the department.'
- Despite this we saw that the recent change to the trust's other ED had affected staff morale. Whilst staff felt strongly that they had made the right decision in influencing the change of the other service to providing urgent care, the local political and media responses had been difficult to cope with and left them feeling their reasoning had been misinterpreted.
- Some uncertainty remained regarding changes to the co-located primary care service. A new organisation was due to provide this service in November 2016, following a tender bidding process but the current provider would cease work in September 2016. Senior managers were liaising with the local clinical commissioning group to ensure service provision continued between September and November.

Public engagement

- Patients were encouraged to complete the NHS Friends and Family survey following their visit to the ED. The average response rate was 15% between June and August 2016 which showed that 73% would recommend services. We saw efforts to raise the response rate with posters in the reception area encouraging people to complete the survey, including options for completion.
- The department was involved in work to educate the public regarding the decision to temporarily change the trust's other ED to an urgent care centre and the impact this would have on the department at Preston. This work included a number of actions to try to ensure the wider public were educated about the decision. We saw that leaflets were available for the public in the reception area which clearly explained the change and what this meant for patients. Clinical managers met with a local Member of Parliament (MP) to discuss the change and what it meant for the local population. Leaflets were also distributed via local doctors' surgeries and executive managers held public meetings as part of the process.
- Senior staff told us they had worked hard to try to reduce the anxiety amongst local people and reassure them the decision was based upon the need to guarantee safe numbers of staff in the department at all times.

Staff engagement

- Senior managers told us that executive (trust) managers liaised with and supported them through the change in service provision for the trust's other ED, which directly affected the department with staff changes and increased attendances. This was done through staff forums and focus groups and visits from executives to the department itself.
- Staff had the opportunity to complete an annual staff questionnaire. The latest results for 2015 were not broken down to departmental level but were provided for the trust as a whole. Results for 2016 showed that only 56% of staff recommended the trust as a place to work, which was worse than 2015 when the result was 62%.

Urgent and emergency services

Innovation, improvement and sustainability

- The department belonged to a national network focusing on supporting and accelerating the local development of ambulatory care through the spread and adoption of good practice and utilisation of improvement methodologies.

Medical care (including older people's care)

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

Information about the service

Medical care services at the Royal Preston hospital provide care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory, stroke and gastroenterology.

There are a total of 281 medical beds at the hospital. The hospital provides medical care services to a population of 390,000 people living in South Ribble, Chorley, and Preston boroughs and between March 2015 and February 2016 there were 29,340 admissions across medical services.

We visited the Royal Preston Hospital as part of our announced inspection on 27 to 30 September 2016 and carried out an unannounced on 14 October 2016.

As part of this inspection we visited the Barton Ward (elderly care), Bleasdale Ward (general medicine), Ribblesdale Ward (oncology), ward 19 (short stay) ward 23 (respiratory medicine), ward 18 (cardiology), ward 24 (gastroenterology), ward 21 (stroke), discharge lounge, cardiac catheterisation suite and the endoscopy unit.

Ribblesdale Ward is an oncology ward and although this was within the surgery directorate at the hospital, we have included it in medical services as per the CQC methodology.

We reviewed the environment and staffing levels and looked at 20 care records and 24 medication records. We spoke with five family members, six patients and 55 members of staff of different grades, including nurses, doctors, ward managers, matrons, ward clerks, allied health professionals, such as physiotherapists and occupational therapists, and the senior managers who were responsible for medical services.

We received comments from people who contacted us to tell us about their experience. We reviewed performance information about the trust and we observed how care and treatment was provided.

Medical care (including older people's care)

Summary of findings

We inspected the hospital in July 2014 and gave medical services an overall rating of Requires Improvement. Following this inspection we rated medical services at Royal Preston Hospital overall as requires improvement because:

- There were staff vacancies in most areas and there were many occasions on wards when there had been a reliance on agency or bank nurses as well as locum doctors with some doctors feeling stressed at times during out of hours cover. Some staff felt that staffing levels could be safer and relatives expressed concern regarding staffing levels on the wards. Data provided showed there were many occasions when the staffing levels were less than 80%.
- Overall compliance with mandatory training for all staff was below trust target. The trust target was 80%.
- Nursing staff did not have access to formal clinical supervision and not all staff had received their annual appraisal.
- There were safe systems of the handling and disposing of medications. However these were not always followed which could put patients at risk.
- There was a risk that personal information was accessible to members of the public as patient's records and prescription charts were not always stored securely.
- There were issues with access and flow across the medical wards with high bed occupancy rates and delayed discharges due to patient choice and complexities.
- Some patients were being nursed in escalation or non-speciality beds and were moved on more than one occasion during their hospital stay with some moved during the night.
- There were governance structures in place which included the risk register however we are not assured of there was clear oversight or ownership of the risk register.
- Policies and procedures were not always reviewed within agreed timelines.

However:

- The trust were monitoring and taking actions regarding staffing levels including rolling recruitment, including overseas and regular monitoring of staffing levels during the day to help mitigate the risk.
- Wards were visible clean and staff followed good hand hygiene practices.
- All staff were aware of the trusts values and vision.
- Staff felt supported by their managers and worked collaboratively together to ensure patient care was prioritised when staffing levels were lower than planned.
- Staff treated patients and their relatives with respect and dignity and communicated with them effectively. Patients were happy with their care, felt informed, and were involved in care planning.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

At the previous inspection in July 2014 we rated safe as requires improvement mainly due to nurse staffing concerns, we have maintained this rating following this inspection. This is because:

- Staffing across medical services was on the risk register and actions had been taken to help mitigate the risk. However, there were occasions where the nurse staffing levels were not overall sufficient to meet the needs of patients, some staff felt at times the levels could be safer and feedback received from a couple of relatives expressed their concern with staffing levels. There was a reliance on most wards to use agency staff and staff to work extra shifts as part of the nurse bank to support ward areas.
- Overall compliance in mandatory training for staff across medical services was below the trust target of 75%.
- An audit performed by the trust showed that there was lack of compliance with monitoring and escalating deteriorating patients across five wards at the hospital.
- There was no formal process for junior medical staff to hand over 'at risk' patients during out of hours. This had been acknowledged by the senior managers who told us this was being addressed.
- There were safe systems in place for handling and disposing of medicines however we saw evidence this had not always been followed and prescription charts we looked at were not always thoroughly completed.
- Patient records were accessible to the public, as some records were left at the patient's bedside and some records trolleys were left unlocked.
- We found used sharps containers which had been left open in unlocked areas, which were accessible to patients and the public.

However:

- Incidents were reported by staff through effective systems and lessons were learned and shared with staff. Although we were not always assured that all actions had been completed.
- Learning from never events and new processes was disseminated to staff.
- Medical wards at the hospital were generally visibly clean and staff followed good hygiene practice,
- There were systems in place to protect people from avoidable harm and staff were aware of how to ensure patients were safeguarded from abuse.

Incidents

- There were systems in place for reporting actual and near miss incidents across medical services. Staff were familiar with the process for reporting incidents and they understood their responsibilities to raise concerns and record safety incidents.
- All incidents were reviewed by the ward manager and the divisional governance or risk team, who ensured all appropriate measures had been taken and investigations carried out, for example when a fall had occurred, risk assessments and preventative measures were put in place and if injuries were sustained this had been managed appropriately. The divisional governance or risk team also monitored themes and trends, which are shared with the safety and quality committee.
- There had been one never event reported at the hospital in August 2015. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented. Senior managers and staff on the unit told us the incident had been fully investigated and changes made to practice. For example, additional checks had been introduced in addition to the World Health Organisation (WHO) checklist to count swabs before and after procedures. All staff we spoke to on the unit were aware of the new process. We saw evidence the incident had been discussed at cardiology governance meetings with actions assigned to a responsible person prior to it being escalated to a never event at cardiology clinical governance meeting in January 2016. We requested a copy of the investigation, however we were told this had not been completed at the time of the inspection.
- From January 2016 to June 2016 there were 3106 incidents reported across the medical division, these were mainly in relation to unwitnessed falls, laboratory investigations/interpretations and inappropriate aggressive behaviour issues towards staff members. Of those, 731 (23%) resulted in harm.
- Trust data showed there have been 15 serious incidents reported across medical services trust wide between

June 2015 and July 2016, 12 of these were falls. A root cause analysis tool was used to investigate serious incidents and we saw evidence that lessons were learned and, where required, and actions were put in place to reduce the risk of the incident happening again. Two action plans we reviewed included a timescale, however, there was no evidence of completion, and therefore we are not assured all the actions were completed.

- Staff told us that learning from incidents was discussed during team meetings or at handover. One member of staff gave an example of an incident and changes to practice following an incident. For example medication is now checked with a nurse and endoscopist following a medication error on the endoscopy unit. We reviewed team meeting on one ward and found incidents were discussed.
- The trust had a policy for duty of candour and all staff we spoke with had an awareness and understanding. 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) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person. Staff understood the principles of the duty of candour and gave examples of when this had been applied.
- The trust provided minutes from mortality and morbidity reviews for services across the medical division, which included surgery. We were unclear as to whether mortality and morbidity reviews where held across medical services, as the only data provided was the minutes from an audit meeting, which included a presentation of mortality review of patients on Medical Assessment Unit (MAU) from January 2016 to April 2016. However, it did not stipulate whether this was at Chorley and South Ribble hospital or at the Royal Preston hospital. The results showed areas of improvement, for example input from the palliative care team and sharing results with the surgical team. Attendees were not documented and therefore we were not clear what representation there was from medical services. We requested further minutes from morbidity and mortality meetings for medical services.

Safety thermometer

- The trust was required to submit data to the health and social care information centre as part of the NHS Safety Thermometer (a tool designed to be used by frontline healthcare professions to measure a snapshot of specific harms once a month). The measurements included pressure ulcers, falls and catheter acquired urinary tract infections.
- From August 2015 to August 2016 there were 33 pressure ulcers reported across medical services at the hospital. In the same period, there were nine venous thromboembolisms (VTE's), eight catheter-acquired urinary tract infections and 12 falls which resulted in harm.
- The trust was participating in the 'NHS sign up to safety' campaign, with the goal to reduce avoidable harm by 50% and save 6,000 lives nationally. A safety improvement plan was developed by the trust, which identified key areas to focus on reducing avoidable falls with harm, reducing avoidable grade 3 pressure ulcers and eliminate grade 4 pressure ulcers and reduce avoidable healthcare infections. An action plan had been developed with actions, goals and timescales. We observed that some of the actions had already been implemented, with others ongoing.
- A falls improvement programme had been implemented, which included completion of SWARM form which was a post fall rapid review following a fall, in addition to reporting the incident. Falls resulting in serious harm were reviewed by the case review group and learning from falls was shared in a quarterly newsletter. We reviewed a completed SWARM assessment following an unavoidable fall, however, it had not been documented whether there were any lessons learned or whether the incident and findings had been fed back to staff.
- Staff on the wards were aware that there had been a high incidence of falls and they explained actions they would take to prevent patients falling, including nursing those at risk in enhanced bays, using alarm cushions and providing slipper socks. Link nurses for the patient safety group disseminated information and were expected to attend falls training. Data provided by the trust showed that staff who had attended falls training trust wide varied across medical services, with trained nurses ranging from 0% (neurology and diabetes) up to 50% (core therapy services).
- Senior managers told us that there had been a reduction in falls and pressure ulcers following the implementation of falls reduction strategies, including falls and pressure ulcer risk assessments being

performed on all patients on admission, the use of falls alarms, falls prevention training and introduction of repositioning charts and a tissue viability link nurse on wards. On reviewing the safety thermometer from the previous year, we noted that during August 2014 to August 2015 there were 28 falls resulting in harm and 76 pressure ulcers had been reported, compared to 12 falls and 35 pressure ulcers having been reported between August 2015 and August 2016.

Cleanliness, infection control and hygiene

- Data provided showed that between April 2015 and March 2016 there were 32 cases of Clostridium difficile (C diff.) reported across medical services trust wide, which was below the target of 35.
- From September 2015 to September 2016 four cases of methicillin-resistant staphylococcus aureus (MRSA) had been reported across medical services trust wide, which was higher than the trust target of 0 and 20 incidents of methicillin-susceptible staphylococcus aureus (MSSA). We do not have the trust target for MSSA.
- Cleaning schedules were in place across the wards, with allocated responsibilities for housekeepers and ward staff cleaning the environment and equipment. We reviewed cleaning schedules on one ward and found it to be incomplete on eight out of the 14 days in October 2016. Staff on ward 21 told us the only cleaning schedules were located on wipe clean boards on the doors of each room. These were completed for the week of inspection however as they were wipe clean there was no audit trail of compliance for the previous weeks
- The wards and areas we inspected were visibly clean and free from odour. All equipment we viewed was clean and we observed the use of 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Hand hygiene audits were carried out monthly across medical wards. Results from hand hygiene audits between January 2016 and October 2016 showed that all the wards achieved above the 95% trust target, apart from July, which reported 85% compliance. We requested action plans from the trust, but we had not received these at the time of report writing
- During our inspection we observed staff consistently followed hand hygiene practice and 'bare arms below the elbow' guidance. Personal protective equipment (PPE), such as aprons and gloves, were readily available and in use in all areas.
- Side rooms were used as isolation rooms for patients identified as an increased infection risk (for example patients with MRSA). There was clear signage outside the rooms, so staff and visitors were aware of the increased precautions they must take when entering and leaving the room.
- We observed that the disposal of sharps, such as needle sticks followed good practice guidance and sharps containers were signed and dated upon assembling them apart from two on Barton Ward. We also on saw that sharps containers did not have the temporary closure in use on five of the wards we visited which meant that used cannulas and needles were accessible to patients and the public. We raised this with staff on the wards.

Environment and equipment

- The wards and areas we visited were well maintained and clinical areas were locked. There were systems in place to maintain and service equipment. Electrical testing had been carried out regularly on electrical equipment and electrical safety certificates were in date.
- Resuscitation equipment was available on all the wards we visited. The contents of each resuscitation trolley were accessible by lifting the lower drawer, which meant that all resuscitation equipment, including intravenous fluids and medication could be accessed by members of the public. There were systems in place to ensure that emergency equipment was checked and ready for use on a daily basis. Records indicated that daily checks of resuscitation equipment had taken place on all the wards.
- Resuscitation equipment was available on all the wards we visited. The resuscitation trolleys were locked, apart from on ward 21, where one was open and an anaphylaxis box in the discharge lounge was not sealed. We escalated each issue to the nurse in charge, who told us this would be resolved. We also noted that intravenous fluids were accessible to members of the public within all the trolleys. During our inspection this was reported to the trust and appropriate actions were taken to secure these.
- Pressure relieving equipment was available from the stores department on site and staff told us that if it was not in stock, then equipment could be ordered directly with the company. However, if this occurred at the

weekend, then patients would have to wait until Monday and they would report it as an incident and increase intentional rounding, during which the patient was reviewed and re-positioned more frequently.
- Wards we visited were fit for purpose, however, there was an issue with lack of space on Bleasdale Ward, where we observed five wheelchairs in the corridor due to lack of storage.
- Two of the three escalation beds on ward 23 were situated at the end of the ward, staff told us this was previously a clinical room. There was no piped oxygen or nurse call bell for patients to use. The nurse in charge told us that the portable call bells had either been misplaced or stolen and replacements were on order, however, patients had access to a - large (and potentially heavy for some patients) hand bell next to the shared television at the end of the beds. Staff told us only mobile, low risk patients would be placed in this room. This was confirmed when we visited the ward on the 27 and 30 September 2016.

Medicines

- There were suitable arrangements in place to store and administer controlled drugs (CD). Stock balances of controlled drugs were correct and two nurses checked the doses and identified the patient before medicines were administered. Daily checks of controlled drugs balances were recorded daily, however from 01/07/2016 to 28/09/2016 there were four occasions when one of the CD cupboards on the endoscopy unit had not been checked.
- Suitable cupboards and cabinets were in place to store medicines. This included a designated room on each ward to store medicines. All medicines we checked on the wards were found to be in date, indicating that there were good stock management systems in place.
- Staff on medication rounds wore red tabards to highlight to other staff that they were not to be disturbed when they administered medication to patients, thus reducing the risk of error.
- We looked at 23 prescription records and observed that 21 were fully completed, dated and had the patient's allergy status documented. However, we noted that on one prescription chart the prescribers name, designation, signature and GMC number had not been completed and on another prescription sheet there was no explanation as to why two drugs had been given.
- There was a process in place if medications were not available on the ward; staff could either access the intranet database to direct them to the ward with stock availability, access the emergency drug cupboard or contact the on call pharmacist. However we are unsure if this process was being followed by all staff as we noted on one prescription chart that a drug had not been administered for 3 days due to not being available but when we asked staff to check availability on the intranet it was identified that the medication was available on other wards.
- Medicines requiring storage at temperatures below eight degrees Celsius were appropriately stored in a fridge. Records indicated that fridge temperatures were not checked daily on three wards we visited and on occasions we observed on Bleasedale Ward the temperature had exceeded eight degrees Celsius. The nurse in charge told us each time this had occurred the physical risk manager and pharmacy team would have been informed. This, however, was not evident on the record sheet we viewed.
- Data provided by the trust showed that there were 375 medication incidents reported across medical services, trust wide, from 4 January 2016 to 31 July 2016. However, we noted that there had been delays in reporting some of the incidents, with the earliest dated back to August 2015. Of the 375 medication incidents, 40 resulted in low harm, four resulted in moderate harm and the rest resulted in no harm. Medication incidents were discussed at the medicines safety group.
- We observed incidents reported and concerns were shared with us regarding unsafe discharges mainly around missing medication on discharge. One incident was regarding a patient who had been discharged without clear instructions for district nurses to crush medication prior to administering. We saw that lessons had been learned and this was shared with staff.

Records

- Patient records were completed electronically and on paper, however, staff we spoke with felt this was not a problem. Patients' nursing paper records were kept at the end of patients' beds, which meant they were accessible to other patients and members of the public.
- On entering patient information, the electronic system prompted staff to follow an algorithm, which staff thought was helpful. For example, if staff entered 'yes' to a patient having a deprivation of liberties in place, this

would prompt staff to report an incident, consider a care package, a mental capacity act review and input any identifiable characteristics, such as tattoos, should the patient go missing.
- We looked at 18 patient records and saw that documentation was accurate, legible, signed and dated. They were easy to follow and medical staff had detailed information for patients' care and treatment.
- Patients had individualised care plans that were regularly reviewed and updated in the records we reviewed.
- Staff completed risk assessments on electronic records and care plans and ongoing care was documented on paper records.
- Patients' medical records were stored in lockable trolleys, however, during our inspection we observed that trolleys were unlocked in the endoscopy unit and patients' records, including observational charts and prescription charts, were kept at the end of patients' beds on all the wards, which increased the potential for patient confidentiality to be breached.

Safeguarding

- The trust had a designated safeguarding team and there was a system in place for raising safeguarding concerns. Staff we spoke with were aware how to access the safeguarding team.
- Training statistics provided by the trust showed that compliance in Level 1 in adult safeguarding training trust wide and Level 1 children's safeguarding across the medical division was above the trust target of 90%.
- Compliance in Level 2 and Level 3 adult safeguarding training across the medical division trust wide, was 61 % and 54% which was below the trust target of 75%.
- Compliance with Levels 2 and 3 children's safeguarding training across the medical division was 33% and 60% which was also below the target of 90%.

Mandatory training

- Mandatory training such as mental capacity, health and safety, fire, manual handling and infection control was available as group sessions or via e-learning. Staff told us they would receive emails to alert them when training was due however some told us they struggled to complete training due to other work commitments.
- Mandatory training was on the divisional and trust risk register and it was noted that mandatory training had been cancelled to facilitate staffing levels. Senior managers told us staff had the opportunity to get paid and complete online training at home.
- Information provided by the trust showed that in August 2016 overall compliance rates with mandatory training for the medical division trust wide was 78% which was below the trust target of 80%.
- Additional data provided by the trust showed various targets for individual courses for example consent was 40% and information governance was 80%. Compliance for nursing staff across the medical division was 47%, with staff achieving the trust target in seven of the twenty eight courses including consent, intravenous administration and conflict resolution. Medical staff across the medical division overall compliance was 52% with four of the 24 courses achieving the trust target including consent and information governance.

Assessing and responding to patient risk

- There was a policy in place for timely recognition and response for patients at risk of deterioration, for staff to refer to. In addition, staff had access and support from the critical outreach team, seven days a week, from 8am until 8pm and overnight from the hospital at night team.
- The National Early Warning Score (NEWS) - tool was used to identify deterioration in a patient's condition. There was evidence in patient notes of this tool being used. Staff were clear about procedures to follow when a patient was deteriorating, by alerting the on-call medic at the earliest opportunity, whilst continuing with vital sign observations. However we saw incidents reported where patients hadn't been escalated as per NEWS.
- Failure to recognise the deteriorating patient due to lack of compliance with accurate NEWS was on the risk register as a significant risk and audits were planned. However, it was unclear when this risk had been initially identified as it was not documented. Data from July 2016 indicated that the essentials of the care audit programme (ECAP) report showed non-compliance with NEWS on five medical wards at the hospital due to inaccurate documentation including Early Warning Scores, fluid balance recordings and frequency of

patient observations. Wards were required to submit an improvement plan. We have requested copies of the improvement plans; however, these had not been received at the time of report writing.

- Upon admission to medical wards, staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways and care plans were put in place, to ensure they received the right level of care. The risk assessments included falls, use of bed rails, pressure ulcer, Venous Thrombi Embolism(VTE) and nutrition (Malnutrition Universal Screening Tool or 'MUST'). We viewed 18 records and saw that risk assessments had been carried out.
- To continually assess patient risk, intentional observation rounds were completed, every one to four hours, depending on patients' needs.
- Patients at risk of Venous Thrombi Embolism(VTE) due to non-compliance with national guidelines was on the risk register dated 20/09/2016 however it was not on the risk register submitted 28/09/2016. No actions were updated and we are not clear as to when and why this was identified as a risk and we were not assured of any actions taken to mitigate the risk. Senior managers were unaware of why this was on the risk register when we asked them during our inspection.
- Trust data from January 2016 to August 2016 showed compliance with VTE assessments across the trust was the same, or greater than the trust target of 95%, however, during the same period 54 incidents were reported for patients who have developed a VTE 48 hours post-admission or within 90 days of discharge, which all were found to be unavoidable. Recommendations including training around the importance of completing timely assessments in line with Trust policy was being provided to junior medical teams, who complete the electronic VTE
- Staff told us patients who were identified as being a higher risk for example of falls were either nursed in rooms adjacent to the nurses station or in enhanced bays where a member of staff would be present at all times, we observed this practice on the wards we visited.
- Patient risks were discussed at staff handover and were also documented on the handover sheet which was provided to every member of the nursing team at the beginning of each shift. However there was nothing highlighted on the electronic record to easily alert staff to any risk including specific information regarding the patient for example if they had dementia.
- Patients with potential swallowing difficulties, and therefore at risk of aspiration, had an assessment by the speech and language therapist (SLT) and if required, a plan of care was documented in patients' records, with specific directions, for example a specific amount of thickener to be mixed with a set amount of fluid. However, we observed that staff did not record when and how much thickening product was added to fluids prepared for patients.
- We reviewed a transfer of patient's policy version 2.3, which had been authorised in February 2013 and was due to be reviewed in June 2013. Information received from the trust states this was under review and was nearly complete, however, this did not provide us with assurance that all current processes were in place and were reflective of current practice and guidelines.

Nursing staffing

- The trust had used the National Institute for Health and Care Excellence (NICE) and National Quality Board approved 'Shelford tool' since 2015. This reviewed acuity and staffing levels, which the trust told us had helped to track the increases and decreases in dependency and acuity of patients and had led to an investment of over 100 nursing posts across wards trust wide.
- Ward managers told us they completed a dependency and acuity scoring system via the e-rostering system, along with professional judgement to identify staffing requirements and clinical competencies on a daily basis.
- Data provided in September 2016 by the trust shows there were nurse vacancies on the majority of medical wards, with highest numbers of vacancies on ward 21 (7.5wte), ward 23 (7.7wte), ward 17 (8.6wte) and MAU (9.1wte). However 47 Staff were currently being recruited into post across the trust and the recent safer staffing review showed that at the end of September 2016 there would be 65 staff (trained and untrained) vacancies across the medicine trust wide.

Medical care (including older people's care)

- The turnover rate of qualified nurses for the past 12 months ranged from 0% to 24% (discharge lounge and ward 21, respectively) and staff sickness for the last financial year was reported between 1.4% (ward 17) up to 20% (discharge lounge).
- The trust undertook biannual nurse staffing establishment reviews as part of mandatory requirements and set key objectives through this work to support safer staffing. Data provided as part of this review, dated November 2016, identified that for 2015/ 2016 the overall fil rate on the medical wards at the hospital was 94% and above and between 77% and 97.3% specifically for trained staff.
- The national benchmark of nursing shifts to be filled as planned during the day and night is 80%. We reviewed staffing figures across 11 medical wards from April 2016 to August 2016 and found that eight out eleven wards did not always achieve the fill rate of 80 % during the day for example in August Bleasdale, Barton and Ribblesdale Ward, MAU and wards 17, 20, 21 and 23 fill rates were between 68.3% to 77.9%.
- During the night, there were six out of eleven wards that did not always achieve the 80% nurse staffing benchmark every month for example, in August wards 18, 21 and 23 fill rates ranged from 71% to 77.4%
- Staffing levels for unregistered staff from April 2016 and August 2016 ranged from 88% to 126.7% during the day. Data provided during the night for July and August 2016 showed staffing levels ranged from 100 to 166.7%. We didn't receive complete data for April to June 2016. Ward managers told us that extra unregistered staff would be utilised to assist with enhanced patients or to help if trained staff were not available.
- Each ward had a planned nurse staffing rota and managers reported on a regular basis if shifts had not been covered. Three methods of triangulation: the Professional Judgement tool', acuity and dependency scoring were used to determine their staffing needs.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the staffing levels that should be on duty and the actual staffing levels. This meant that people who used the service were aware of the available staff and whether staffing levels were in line with the planned requirement.
- At the time of inspection, not all the shifts were filled as planned, despite agency and bank nurses being used to help fill staffing shortfalls, however, the ward managers felt the staffing levels were safe but one told us they felt it could be safer. We received feedback from relatives who felt the staffing levels were unsafe with one stating on occasions they stayed overnight with their loved one.
- The matron told us that staff were moved to support other wards at a week at a time to maintain familiarity and continuity of care for both the staff member and patient.
- Senior staff on the wards told us that staff would work overtime, or on the bank. Agency staff were requested and ward managers would try to use the same bank and agency staff to ensure that they had the required skills and continuity on the ward. We observed rotas which confirmed this, however, some shifts remained unfilled, which meant that there was a risk that patients did not receive the care they needed on these occasions.
- All ward staff we spoke told us they ''were doing their best'' and ''working hard as a team'', Ward managers told us that they would escalate any concerns to the matron, prioritise care and nurse at risk patients in enhanced bays to maintain safety of all patients. Some ward managers told us they rarely managed to have 'management days', as they were required on the wards and had worked extra hours themselves.
- From 4 January 2016 to 31 July 2016 we saw 98 incidents reported from staff at the hospital regarding shortage in staffing levels on the ward, some indicated they were short due to staff being moved to other wards to cover escalation beds.
- Nurse staffing levels was on the risk register. Senior managers told us there had been high levels of sickness, which was improving in addition to vacancies. Actions were being taken to mitigate risk, including reviewing recruitment processes and job adverts, facilitating recruitment events, recruiting abroad and maintaining a rolling recruitment programme for health care assistants and nursing staff. The trust had also commenced a pre-nursing apprenticeship programme and were working with the local university regarding placement of nurses on wards as part of preceptorship. However, senior managers told us that there had been no student nurse intake at the local university for the past 12 months and this has had an impact on recruitment and workforce planning.
- Matrons met with ward managers twice a day to discuss and monitor nurse staffing levels and ensure staff and skill mix were appropriately deployed and shared across all wards. However on a day during our inspection the

matron was unaware that there were staffing issues on Barton Ward due to staff sickness. The Nursing and Midwifery Director met with the Heads of Nursing weekly to manage and monitor the situation. Staffing was also monitored at monthly board meetings.

- We saw effective handover meetings between nursing staff and health care assistants, which were well-structured and highlighted key risks and plan of care for each patient. Each member of staff had a completed handover sheet, which had all relevant information documented including deteriorating patients, medical history and any requirements for the day.

Medical staffing

- The percentage of consultants working at the trust was 39%, which was higher than the England average of 37%. The percentage of middle grade doctors (6%) and junior doctors (21%) was the same as the England average, however, registrars was 34% which was lower (worse) than the England average of 36%.
- Between April 2015 to April 2016 the turnover rate of medical staff was variable across the specialities, for example it was 0% for the diabetes department, 6.8% for respiratory, 22.2% for cardiology and 26.7% for MAU.
- Data provided by the trust showed that there were 18 medical vacancies at the hospital with four covered by trust locums. The data didn't stipulate what grade of doctor the vacancies were for. Senior managers told us they have been using the same locums on a regular basis to help fill the gaps. However, the trust were actively recruiting and were reviewing ways to increase recruitment, including overseas recruitment and looking at offering junior and middle grade rotational posts and combined posts for consultants.
- Medical staffing levels were on the divisional risk register and was discussed at the medicine divisional board meetings.
- Medical staff told us there was sufficient medical cover outside normal working hours and at weekends should patients need to see a doctor however some told us it could be stressful -dependent on patient need. We were told consultant cover was available on site from 9am to 8pm daily Monday to Friday and at weekends from 9am until 1pm. Outside these hours, a consultant was on call and was within 30 minutes travel time to the hospital.
- Senior managers told us there were challenges in arranging cover for the gastro-intestinal (GI) bleed rota, to cover both Chorley and South Ribble Hospital and Royal Preston Hospital, due to staffing, however, ongoing recruitment had nearly been achieved. The surgical team covered the rota with support and access to an upper GI surgeon at all times. We were told there was ongoing monitoring of the situation and no incidents had occurred.
- There was no pathway or clear process for junior doctors to handover 'at risk' patients to the overnight on call team and two junior doctors told us it was down to 'good will' to contact the on call doctor and hand over patients. We saw a serious post incident report where the delayed review of an acutely unwell patient admitted to a ward over the weekend was detrimental to the patient. Senior managers told us they had visited two other trusts to look at ways of improving the process and were going to submit an action plan.
- However every night at 9pm, the onsite night manager, medical staff and the hospital at night team met to discuss issues, including bed capacity, medical outliers and deteriorating or potential deteriorating patients. The onsite manager would hand over to the day time onsite manager, who then attended the 9am meeting with the medical staff and matrons.

Major incident awareness and training

- The trust had a major incident plan in place, which listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of different types of major incidents
- Staff we spoke with were aware of the major incident plan and how to access it.

Are medical care services effective?

Requires improvement

At the previous inspection in July 2014 we rated effective as requires improvement mainly due to improvements being needed in the management of patients with diabetes, especially with regard to foot risk assessments and patients who had had a stroke. We have maintained this rating following this inspection because:

- Medical services participated in the majority of clinical audits where they were eligible to take part. However

recent national audits indicated some services had worsened and further improvements were required in the care for people with diabetes or who had had a heart attack or had suffered a stroke.
- We found that actions following local audit were not always monitored or reassessed to measure improvement or impact.
- Diabetes care was not provided in line with national best practice. Staff had access to policies and procedures although these were not all reviewed or updated within the set timeframe.
- Most staff said they were supported effectively but the majority of staff who had received their annual appraisal was mainly below the trust target.
- The number of staff who had completed mental capacity act training was below the trust target however staff demonstrated a good understanding and awareness around mental capacity.
- Not all services provided a seven day service at the hospital.

However:

- The endoscopy unit had been formally recognised that it had competence to deliver against the measures in the endoscopy GRS standards and has received JAG accreditation in 2014.
- Nutrition and fluid intake were recorded correctly and support was provided for patient that needed assistance with eating and drinking.
- Patient's pain relief was monitored effectively.
- There was a focus on discharge planning and there was good multidisciplinary working to support this.

Evidence-based care and treatment

- Medical services were using national and best practice guidelines to care and treat patients, for example with Chronic Obstructive Pulmonary Disease (COPD) to improve performance. We reviewed minutes from a diabetes meeting in March 2016, which stated that the recent diabetes survey showed that the trust were not adhering to NICE guidelines, as patients were not having their feet assessed on admission as there was no hospital based multidisciplinary foot team for in-patients.
- Staff told us policies and procedures reflected current best practice guidance and were available electronically on the trust's intranet. We reviewed a selection of policies and found that some, including transfer of patients and the escalation policy, had not been reviewed within the stated timelines, which therefore did not assure us that policies reflected the current guidance and needs of patients.
- The service participated in the majority of clinical audits they were eligible for through the advancing quality programme.
- Trust data showed examples of recent local audits that had been completed on the wards, including monthly medicines spot checks, documentation audits and compliance with the MUST tool.
- Staff told us about recent local audits that had been completed on the wards; these included clinical care indicators, such as nutrition and pain management. We observed minutes of a team meeting, where results of audit had been discussed along with lessons learned.
- We reviewed four audits undertaken within the last 12 month however it was unclear on one audit as to which hospital this was undertaken. The audits identified areas of good practice and areas of improvement. Action plans were in place to improve standards, however, we observed on the audit of patients records that actions were either not actioned or in progress with no review date or responsible person documented. In addition on an audit carried out by the SALT team we saw no further evidence of re-auditing within the proposed time frame. We were therefore not assured that there was any improvement following the audit or if the results and recommendations were shared.
- The Trust had an essentials of care audit programme (ECAP), which measured care provided by individual wards in relation to nutrition, falls, medication, NEWS ,pain and tissue viability and results were demonstrated using a RAG (red , amber , green) rating. We viewed an audit report from July 2016, which gave overall trust wide scores of individual wards across the trust.
- Safety crosses were completed and displayed on notice boards. A safety cross represented each calendar month and was completed daily to monitor avoidable harms such as falls, pressure ulcers, venous thromboembolism (preventing blood clots) and infections (MRSA and C-diff). These were visible to staff, patients and relatives. Staff told us the data was reported and discussed at staff handover and at team meetings. We observed this during our inspection.
- Medical services at the hospital participated in the joint advisory group on gastro-intestinal (JAG) endoscopy

and had achieved JAG accreditation in April 2014. The JAG accreditation scheme ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced.

Pain relief

- Pain relief was managed on an individual basis and was regularly monitored for efficacy. Patients told us that they were asked about their pain and supported to manage it. However, staff on Ribblesdale Ward felt there was a risk that patients would not receive pain relief in a timely manner due to staff shortages and we saw a complaint where this had occurred. During our inspection we spoke with three patients on the ward, who told us they had received pain relief quickly.
- We saw completed pain assessments as part of the NEWS in patients' records.
- The trust told us that there was a specific pain assessment tool for use with patients living with dementia. However, staff we spoke with on two wards were unaware of a specific tool although staff on ward 20 and Ribblesdale ward said they would print out pictures as a visual aid for those patients who had difficulties communicating.

Nutrition and hydration

- Fluid balance charts were regularly completed and records showed that patients had an assessment of their nutritional needs using the malnutrition universal screening tool (MUST). Patients were referred to a dietician where necessary.
- We saw there was a comprehensive selection of meals available from different menu's including halal, renal and high calorie diet, which was available for patients in addition to finger foods.
- Dieticians and speech and language therapists (SALT) were available on weekdays across the trust and staff knew how to access the services. A discreet sign was placed at the back of the patient's bed to state what type of diet is required, for example if a soft diet was required.
- During our inspection, we observed patients being offered and provided with drinks and food, including finger food, which supported nutritional intake**.** Drinks were within reach of patients**.** We saw staff assisting patients to eat and drink, whilst promoting compassion, dignity and independence. All the patients we spoke with said they were happy with the standard and choice of food available.
- Protected meal times were in place across the wards. The purpose of protected meal times is to allow patients to eat their meals without unnecessary interruption and to focus on providing assistance to those patients unable to eat independently.

Patient outcomes

- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. The MINAP audit 2014/2015 showed the percentage of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI)), could have been managed better at the hospital with results below the national average. For example 84% of patients were seen by a cardiologist, which was worse than the national average of 94.8% and 25.5% of patients were admitted to a cardiology ward, which was worse than the national average of 56.9%. Senior managers were unaware as why the number of patients admitted to a cardiology ward was low as they told us there were no current issues but told us they would look into it. We have requested the action plan but at the time of report this has not been received.
- The sentinel stroke national audit programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. Audit results from April 2016 to June 2016 rated the hospital overall as a grade 'D', which had decreased from a grade 'C' rated in March 2016. This showed us that improvements to the care and treatment of patients who had suffered a stroke were still required. Senior managers told us an action plan had been implemented and would provide a copy. However, this had not been received at the time of writing the report.
- The 2013/2014 heart failure audit showed the hospital performed better than the England average for ten out of the eleven clinical indicators.
- In the national diabetes inpatient audit 2015, the hospital was worse than the England average in 16 of the 17 indicators, this included patients receiving a foot assessment within 24 hours, medication errors, and meal choice and staff knowledge. Senior managers told us they were looking at setting up an integrated service

with primary care and that an action plan had been devised; we requested a copy of the action plan, however, at the time of inspection we had not yet received it.

- Data from the Lung Cancer Audit (2015) showed mixed performance in the quality of care at the trust. The trust achieved the expected or exceeded level in the process, imaging and nursing measures in two of the four indicators. Treatment measures achieved the expected or exceeded level in two indicators, and were significantly better than the national level in one. However they were below the expected level on two indicators and significantly worse on one treatment measure. The action plan following this audit has been requested however at the time of writing the report we had not yet received it.
- Between February 2015 to January 2016, Hospital Episode Statistics (HES) data showed the readmission rates for non-elective and elective admissions at the hospital was better or similar than the England average; however for gastroenterology they were worse than expected. When we spoke to senior managers they told us they were looking into the data as they felt this wasn't correct as well as non-elective general and respiratory medicine.

Competent staff

- According to trust figures, at the end of July 2016 not all staff across medical services trust wide had received their annual appraisal, with compliance varying from 44% (additional professional scientific and technical staff) to 82.8% (medical and dental staff). The trust target was 80%. Staff we spoke to told us they had received an annual appraisal.
- Senior managers told us that clinical supervision for non-medical staff was not embedded across the trust. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice to encourage improvement.
- All new staff were required to complete a full day corporate induction and a local induction before undertaking their role with new nurses on the wards we visited were supernumerary up to four weeks.
- Qualified staff on the stroke ward were trained in performing swallowing assessments. This ensured patients were assessed in a timely manner and could commence on diet and fluids at the earliest opportunity
- Band 3 health care assistants on Ribblesdale ward were being trained up to band 4 with in house competencies, including administering feeds and supervised checking of controlled medication.

Multidisciplinary working

- Multidisciplinary team (MDT) was well established on the wards with patients having input from a range of allied healthcare professionals (AHP's) including Occupational, physiotherapy and speech and language specialist. Plans of care were available to staff to review patients goals. Staff on the stroke ward told us that AHP staff would add specific information onto the staff handover throughout the day.
- There was a cohesive and thorough approach to assessing the range of people's needs, setting individual goals and providing patient centred care.
- Nursing staff worked alongside other staff to provide a multidisciplinary approach and all staff we spoke to described good collaborative working practices. For example staff on Ribblesdale Ward told us the medical staff would assist nursing staff in duties such as administering medication when they were short-staffed.
- Doctors told us they worked closely with ward staff, case managers and discharge liaison nurses, in preparation and planning for a complex discharge.
- There were specialist teams, including the tissue viability team and diabetes nurses who could be accessed for support, advice and provide joint patient care.
- Daily meetings, called board rounds, were attended by consultants, discharge planners, nurses and doctors. Board rounds were held Monday to Friday and we were told that the purpose was to review patients and complex discharges.
- Senior nursing and medical staff would met twice a day at 9am and 9pm every day to handover patients including those at risk or deteriorating, determine priorities capacity and demand.

Seven-day services

- Staff and patients told us diagnostic services were available 24 hours a day, seven days a week.

Medical care (including older people's care)

- Not all services were providing seven-day services, however, the cardiac catheterisation suite (CCS), the endoscopy unit and the dialysis unit were available 24 hours a day, seven days a week for emergencies.
- There was a designated hospital at night clinician seven days a week who supported nurses and managed any issues including staffing at the hospital.
- The stroke specialist nurses were available from 8 am to 8pm seven days a week with ward staff providing thrombolysis care outside of these hours. In addition the stroke consultants were also on site from 9am to 5pm Monday to Friday and from 9am to 1pm at weekends to review new patients and provide cover in the Transient Ischaemic Attack clinic.
- Pharmacists were available seven days a week and staff told us they could be contacted out of hours if there was a query regarding medication or discharge medication was required.
- The discharge team, including a social worker, operated seven days a week, from 9am to 5pm, which meant patients who were well, could be discharged over the weekend.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- There were computers available on the wards we visited, which provided staff access to patient and trust information. Some doctors we spoke to told us as busy times there was a shortage of computers and on occasions this caused difficulty in ordering take home medications and review diagnostic results.
- Policies and protocols were kept on the hospital's intranet, which meant all staff had access to them when required.
- On each ward there was an electronic patient board with details regarding each patient, including diagnosis, investigations /procedures required and discharge planning.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Trust data confirmed that mental capacity act (MCA) training was included in safeguarding training. Overall compliance across medical services trust wide was below the trust target of 75% with 57% of medical staff, 59% of nursing staff and 68% of allied health professionals had attended training in MCA.
- Staff we spoke with demonstrated awareness and understanding about the key principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to patient care. The Deprivation of Liberty Safeguards (DoLs) are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. We saw completed DoLS assessment which were in line with guidance and best practice.
- Staff knew the principles of consent and we saw written records that indicated consent had been obtained from patients prior to procedures.
- Compliance with consent training for qualified nursing staff was 100% across medical services trust wide.

Are medical care services caring?

Good

At the previous inspection in July 2014 we rated caring as good, we have maintained this rating following this inspection because:

- Patients told us staff were caring, kind and respected their wishes.
- We observed positive patient-centred interactions with patients.
- Both patients and relatives were complimentary about the staff that cared for them and told us they were involved in their care and were provided with appropriate emotional support
- We spoke to five patients' relatives during our visit, who all gave positive feedback about the staff and told us that they were caring and respectful.
- Chaplaincy services were available throughout the hospital for patients, relatives and staff.

Medical care (including older people's care)

Compassionate care

- During our inspection we observed patients being cared for with dignity, respect and kindness with privacy maintained at all times. All patients who were at their bedside or in bed had access to call bells and staff responded promptly.
- Patients on the CCS, endoscopy unit and the discharge lounge had access to dignity suits which provided the clinicians with practical access but maintained the patients dignity if they had no nightwear or appropriate clothing.
- All the patients we spoke with were positive about their care and treatment. Comments included ''the care is super from every member of staff'' and '' staff are excellent ''.
- Between June 2014 and July 2015, the NHS Friends and Family Test (FFT) overall response rate across the medical wards for this trust was 34%, which was better than the England average of 26%. The NHS Friends and Family test (FFT) asks patients how likely they are to recommend a hospital after treatment. The scores from July 2015 to June 2016 were variable, with scores ranging from 0% and 100%. However the cardiac catheterisation suite scored 100% in five months, MAU in three months, ward 20 and 21 each in two months and ward 23 in one month which indicated that patients were positive about their experience.
- In the cancer patient experience survey 2015, the trust scored above average in 13 out of the 50 questions, whilst with the other questions the trust performed lower than expected.
- The trust performed about the same as similar trusts in all areas of the 2015 CQC inpatient survey. In response to the survey, the trust implemented an action plan with ongoing actions, including working with the research directorate to improve access to cancer research and the development and implementation of e-books to improve patient information.

Understanding and involvement of patients and those close to them

- All patients we spoke with said they had received ongoing, clear information about their condition and treatment.
- Patients on the wards we visited did not have a named nurse and staff told us this was because they worked as a team, although during handover we noticed that nurses were assigned bays and side rooms.
- The trust were participating in 'John's campaign', which focused on caring and supporting carers to stay with their loved ones in hospital and have dementia. Badges were provided to carers of patients with learning disabilities or dementia; this ensured all staff were aware of who the carers were and staff told us they valued and liked to include carers to be part of the team. Staff told us they would arrange for subsidised parking at the hospital and offer carers a drink and a meal if there was any left over from the patients' meals trolley.
- Patients and relatives we spoke with all told us that staff were busy but were responsive to their needs approachable.
- Relatives we spoke with said they were well informed of patient's condition and plan of care. We saw evidence in patients' records that relatives were kept informed of the patient's condition.

Emotional support

- Visiting times met the needs of the relatives we spoke with. Open visiting times were available if patients needed support from relatives**.**
- On the endoscopy unit, family and friends could wait in the separate waiting area, however, staff were aware of the positive impact of having carers present for those with additional needs. Carers were allowed to stay with the patient throughout the process if this was the patient's choice.
- At the hospital there was a chaplaincy team available 24 hours a day, seven days a week. The team consisted of chaplains and volunteers from all denominations. Staff would visits wards and offer support as required and would take patients to weekly prayer or services.

Are medical care services responsive?

Requires improvement

At the previous inspection in July 2014 we rated responsive as requires improvement, this was because

bed occupancy for the trust was consistently higher than the England average and some of the escalation areas used were unsuitable. We have maintained this rating following this inspection because:

- There were on going issues with access and flow patients across medical services mainly due to high occupancy rates and difficulties in discharging medically optimised patients due patient choice.
- Across medical services, there was a high bed occupancy rate, which also impacted on the amount of outliers on other wards and escalation beds and there had been one mixed sex breach reported.
- The cardiac catheterisation suite was frequently used as an escalation area despite the policy stating it was to be used in extreme circumstances. This also resulted in procedures being cancelled on the unit.
- The average length of stay at the hospital was worse than the England average for all elective admissions.
- There were a number of patients who were being cared for in non-speciality beds. There was a high number of patients who moved ward during the night and nearly two thirds patients experienced one or more moves during their stay.
- The location of the discharge lounge was accessible and used as a thoroughfare by patients accessing the outpatients department, this meant that patients awaiting discharge from hospital may not have their dignity and privacy maintained at all times.
- Three of the six specialities across medical services trust wide performed worse than the national average in the 18 week referral to treatment indicators.

However;

- The trust were working with local and social providers and CCG to address issues and had plans in place.
- There were specialist nurses who provided support and advice to staff and the service was mostly meeting individual needs for patient who had dementia
- People were supported to raise a concern or a complaint.
- There was access to translation services and leaflets available for patients about the services and the care they were receiving.
- The hospital participated in number of schemes to help meet people's individual needs, such as the Quality Mark for Elder-Friendly hospital wards' 'John's campaign'.

Service planning and delivery to meet the needs of local people

- The premises and facilities were appropriate for the services they planned and delivered. However, we found that the discharge lounge although was a dedicated area it was a thoroughfare to the outpatients department and we weren't assured that patients dignity and privacy was maintained within this environment
- Barton and Bleasdale Wards were located in a separate building within the hospital grounds and transferring a patient to or from the ward to the main hospital was via an ambulance. On the day we inspected, a patient on Barton Ward attended an outpatient's appointment, which required an ambulance, along with a member of staff from the ward to chaperone. The, ward sister told us this can have an impact on time and staffing levels on the ward.
- The hospital participated in the Quality Mark for Elder-Friendly Hospital Wards, with three wards (ward 21, Bleasdale Ward and Barton Ward) achieving the quality mark. The elder friendly quality mark is quality-improvement programme, which ensures a consistent quality care to patients over 65 years of age.
- The Proactive Elderly Care Team (PECT) provided patients and staff in identifying and assessing needs of older people and carried out dementia assessments for patients over the age of 75 years of age.
- Escalation beds were opened in response to high levels of bed occupancy. Staffing was not increased when escalation beds were utilised, as senior managers told us that staffing was reviewed prior to opening the beds. Escalation beds were situated on ward 21, 23 and the cardiac catheterization suite (CCS).
- The CCS was deemed an area unsuitable for escalation in the trust capacity plan and an escalation policy was written specifically for the CCS, which stated that beds should only to be used in extreme circumstances. The beds were attended by staff from ward 23, which was located opposite the unit and patients showering facilities were also located on ward 23. Staff on the CCS told us that escalation beds were regularly used and on occasions there were patients in the beds who required extra supervision, which was against the policy. Data provided by the trust showed that from January 2016 to August 2016 there had been a total of 1435 overnight bed stays on CCS. We saw four incidents which had

been reported between April and July 2016, regarding unsuitable patients being admitted into escalation beds on the CCS for example requiring monitoring or were aggressive.

Access and flow

- Between November 2015 and June 2016 performance against national referral to treatment indicators (RTT) for 3 medical specialities trust wide, cardiology, gastroenterology and general medicine were below the national average. Board meeting papers confirmed that the trust worked with the Clinical Commissioning Group (CCG) and NHSI and an action plan with targets was implemented. We observed 'failure of 18 week compliance' was on the risk register, however, it was unclear whether this was for all specialities, although it did state a joint recovery plan had been developed with the CCG and a Neurology pathways group has been set up.
- Hospital episode statistics (HES) showed that the average length of stay was more than the England average for all elective admissions and similar than the England average for non-elective specialties.
- Between July 2015 and March 2016, the occupancy rate across the trust was between 91.5% and 94.3% which was higher than the England average. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Information provided by the trust showed there were a large number of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers).Trust data showed from July 2015 and July 2016 there was on average 49 to 75 outliers per day at the hospital. Senior managers told us this had reduced over the recent weeks and at the time of inspection there were 23 outliers.
- We reviewed the records for four medical patients who were outlying on surgical wards and found that three of the four patients had been seen daily by a member of the medical team. Staff told us that matrons would contact the ward each day to ensure the patients were reviewed by their medical team and they told us they had contact arrangements for the relevant speciality teams in and out of hours however we are not assured this was taking place as one medical outlier hadn't been reviewed on a daily basis.
- The trust had an escalation policy, which included management of outliers. However the policy was dated 2014/2015, so we were not assured that this had been recently reviewed to reflect the current demands and needs of the hospital. Following our inspection, the trust provided a copy of a medical outlier's policy, version 1, which had been ratified in September 2016, however, we were unsure if this was currently being followed, as there was no documentation to clarify which committee had ratified it and there was no review date or issue date.
- Data provided during our inspection showed that from January 2016 to August 2016 there had been 141 cases cancelled on the CCS due to beds being used for escalation although staff also told us that they had to arrange for extra lists to cope with the backlog.
- In the period August 2015 to July 2016, 45% of patients experienced one ward move during their stay, 20% had two moves, 6% had experienced three moves and 3% had been moved four times.
- Additional trust data showed that between January 2016 and July 2016, a number of patients on medical wards were transferred to another ward between 10pm and 8am, for example 95 patients had been transferred from ward 24 (gastroenterology) during the night, 72 patients had been transferred from the medical assessment unit and 401 patients had been transferred from ward 19 (short stay Ward).
- During the past 12 months there had been one mixed sex breach which had occurred on the acute dialysis bay (ward 25). We viewed a mixed sex procedure specifically for the dialysis bay for staff to follow in the event of managing a mix sex breach.
- Discharges were often delayed due to waiting for care packages (4.2%, which was better than the England average of 17.7%), awaiting a nursing home placement or availability (15.4% compared to the England average of 13.7%) and patient / family choice (52.4% compared to England average of 12%). Senior managers were aware of the high percentage due to patient or family choice, but did not have any plans in place to address the issue. Senior managers and matrons were emailed an update regarding patients who were medically fit for discharge and had actions and plans in place in order to facilitate the discharge.
- The discharge team manager met weekly with the social and community care providers, along with a member of the local clinical commission group, in order to discuss

patients who were in hospital and required support for a length of time in the community. We were told this had not yet had an impact on discharges, however, they felt that the meetings had increased partnership working, along with increasing awareness to problems.

- The weekly Guardianship is a report that is distributed to matrons and case managers providing them with an overview of patients who had been in hospital for more than 21 days or for those patients who had multiple moves during their in-patient stay. Senior managers told us to improve flow of patients this report would now be produced every five days instead of 21.
- Meetings on bed availability were held once a day to determine priorities, capacity and demand for all specialities. These were attended by both senior management staff and senior clinical staff.
- Staff were focused on discharge planning for patients and wards. Staff discussed discharges at handovers, the daily board round and at the bed management meeting, with emphasis on 'golden discharges', where the aim was to get patients discharged from hospital before 10am.
- The trust were rolling out an electronic system to allow discharge letters to send to GPs' via email however at the time of inspection this was not set up for all surgeries and therefore information was sent in the post. Referrals to other services, for examples district nurses, was emailed and staff told us a receipt email would be obtained to prove it had been done.
- Patients received a printout report following their procedure on the endoscopy unit; this report would also be sent to their GP.
- There was a short stay ward (ward 19) in place of the MAU, staff were shared between the ward and accident and emergency.
- Patients were admitted from either the Accident and Emergency Department (A and E) or the Emergency Decisions Unit, with the expectation to be discharged within 72 hours. However, during our inspection staff told us that this was not always the case and gave us examples of current inpatients who had been on the ward longer, for example, one patient had been on the ward four days, three patients for three days and nine patients for two days, the other 12 patients had been admitted onto the ward within 24 hours.
- The trust had commissioned and worked with 'Four Eyes Insight' to improve patient flow. This work included standardising practices on the wards, including daily board / ward rounds and review of the consultant's job plans to ensure capacity to support ward clinical work.

Meeting people's individual needs

- There was a dementia team at the hospital that supported both staff and patients. Staff on a ward told us they contacted the team regarding a patient who was unsettled and a member of the team sat with the patient for a few hours.
- Monthly tea parties were arranged by staff on Barton Ward with cakes provided by the kitchen staff and volunteers would bring in the prizes for the raffle. Staff told us invites would be left at each patient's bedside, so families could also attend
- The trust used the 'forget me not' and the 'hospital passport' documentation for carers, to record information about patients living with dementia or a learning disability. This ensured that staff knew the patients' likes, dislikes and ensured their needs were met. Trust data showed there were 103 dementia champions across medical services at the hospital.
- Translation services were available across the trust, which included face to face, telephone and written translation.
- During our inspection, we observed 'activity boxes' on some of the wards we visited, with games and books aimed at elderly patients to use, staff told us other wards had access to them when required. Patients with dementia had access to dolls and activity blankets, which were made by staff and sewing volunteers.
- There was a wide range of specialist nurses and teams, for example diabetes, stroke and renal nurses, who offered specialist advice to staff caring for people with these conditions. Staff told us they knew how to contact these specialists and felt supported by them.
- The manager on the endoscopy unit told us that there was nothing formally in place for patients with learning disabilities or dementia; however, the patient's carer could stay with the patient throughout the procedure.
- Information for patients about services and care they received could be accessed via information leaflets and the trust intranet, which could be translated into different languages, both in audio and written format.
- Pharmacists applied a sticker on patient's records to remind staff if the patient required a dossette or tablet

organiser to be arranged prior to discharge. The medicines management dashboard in April showed a 92% turnaround of discharge prescriptions in average of 44 minutes (the target was 90 minutes).

Learning from complaints and concerns

- Trust data showed that between April 2015 and April 2016, there had been 193 complaints raised across medical services trust wide. The highest proportion of complaints related to all aspects of care and treatment. However, all patients we spoke with told us they were happy with the care and treatment they received.
- Patients and relatives could raise concerns in various ways, including email, in writing, in person or over the phone. We observed posters around the hospital with details about how to raise concerns and staff told us that members of the patient advice and liaison service (PALS) team would visit the wards weekly and speak with staff and patients.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- Complaints were risk assessed and delegated to the appropriate divisional governance team by the customer care team, with the chief executive having overall insight and overall responsibility. The trust had access to the patient and advice liaison service (PALS) to support staff, patients and relatives through the process.
- Complaints were discussed at governance meetings across the trust, including the safety and quality committee. The minutes stated that a report containing data regarding complaints including themes, trends and lessons learned were shared at the meetings.
- We reviewed data submitted by the trust regarding a complaint in 2013 regarding care across medical services. An action plan was devised, but we were unclear as to when as there were no dates again each action or when actions had been completed although it did state that training and pathways implemented were disseminated to staff July 2016. In addition we were unsure if complainants received an acknowledgement or a response from the trust, and if this was done in a timely manner.

Are medical care services well-led?

Requires improvement

At the previous inspection in July 2014 we rated well led as requires improvement, this was because the vision for the medicine division lacked clarity and some junior doctors felt less supported due to consultant vacancies. We have maintained this rating following this inspection because:

- There was a governance structure in place but there was limited evidence of actions being monitored within identified and agreed timelines.
- Risk registers were in place, however, there were inconsistencies across the divisional and trust risk register including identification of risk and risk scores which did not give us assurance that medical services had full oversight of the risks or that risks were being monitored and actioned in a timely manner.
- The medical division incorporated specialities trust wide and included accident and emergency, paediatric and medicine. Data wasn't always disaggregated to service level but reported as a division which meant it was difficult to monitor performance to speciality and hospital.
- Minutes from key divisional meetings discussed governance issues and although actions identified had a responsible person, there were no time lines, which did not assure us actions were being managed effectively or within an agreed time frame.
- The 2015 NHS staff survey results showed that the trust scored worse than the national average in effective team working, organisation and management interest and action on staff health and wellbeing. In addition the scores showed that 13 of 23 indicators were worse than the previous survey.

However;

- All staff we asked were aware of the trust vision.
- Staff felt supported and able to speak up if they had concerns and the number of staff who felt comfortable reporting unsafe clinical practice was similar to the England average.
- The trust had participated in improvement programmes and worked alongside other services and were successful in reducing delayed transfers of care of patients.

- Staff and patients would recommend the hospital to friends or a relative.

Vision and strategy for this service

- The trust's vision is to be a leading provider of joined up healthcare that would support every person who needed services, in addition to providing excellent care with compassion. The values were to be caring and compassionate, recognizing individuality, seeking to involve, team work and taking personal responsibility.
- All staff we asked were aware of the vision and values and they were displayed on the notice boards on the wards we visited.
- The Medical division had a local strategy plan for 2016/2017, which outlined plans, priorities and areas of focus, including the provision of seven day cover and a review of the MAU function. The plans also identified opportunities and challenges in meeting the objectives

Governance, risk management and quality measurement

- The medicine division had recently been restructured and covered 3 specialities: acute medicine, long term conditions and specialist medicine across two hospitals; Royal Preston hospital and Chorley and South Ribble hospital. Medical specialities along with emergency medicine, paediatrics and critical care were within the division. Some data provided by the trust was collated as a whole division and therefore it was difficult to monitor the performance of specific areas or hospital in for example training and reporting incidents.
- Monthly trust wide divisional safety and quality executive committee meetings were held at the hospital and attended by senior managers. Governance issues, including the safety and quality dashboard, divisional risk register, complaints and patient experience were discussed at each meeting, with actions assigned to individuals. However, no timelines were documented, which meant it was difficult to track progress.
- We reviewed the minutes of trust wide clinical governance meetings for individual services within the medical division, which were mainly held monthly, apart from the cardiology service, which was held quarterly. It was difficult to identify on the attendees list whether there was staff representation from each hospital. It was clear from the minutes we reviewed, that each service had different agenda's, with most services discussing performance and all services, apart from stroke services, respiratory services and diabetes services reviewing incidents. Actions from the meeting were identified in the minutes, along with the person responsible. However, there was no target date for the actions to be completed. It was therefore difficult to track progress against agreed actions.
- We reviewed three medicine divisional board minutes and found discrepancies with dates in two of the three minutes and therefore we were not clear exactly when the meeting or previous meeting had taken place. Safety and quality, along with staffing, was discussed in two of the meetings and discussion regarding the Accident and Emergency department's staffing crisis was discussed at the third meeting. All actions had an assigned person, but did not have a timescale and the minutes dated May 2016 had four outstanding actions with a question mark again them. This did not assure us that actions were being addressed or actioned in a timely manner.
- There were inconsistencies across the trust and medicine divisional risk registers, for example with details and risk scores, along with additional risks reported on the trust wide risk registers, that had not been captured on the medical risk register. On requesting a copy of the risk register, inspectors received different versions and therefore we are not assured that risks were being managed and monitored consistently.
- The medicine divisional risk register was not specific to medical areas and included risks for the entire division of medicine trust wide, including outpatients and accident and emergency. Each risk was identified as trust wide, specific speciality and/or hospital. We were not assured actions were being managed as both risk registers did not clearly identify or manage risks as there was no current or additional mitigation action, a responsible person for each risk and on the trust wide register there were no time frames documented on the trust wide risk register which did not assure us that actions were being taken.

Leadership of service

- The governance structure for medicine consisted of the Divisional Medical Director, Divisional Director and the Head of Nursing. Each of the three specialities had a clinical business manager and two speciality managers along with matrons representing each service.

Medical care (including older people's care)

- Staff were aware of who the matrons specific to their area were and the majority of staff were aware of who the executive team and senior managers were and felt they were visible around the hospital.
- All nursing staff spoke highly of ward managers and matrons and told us they were supportive regarding any issues on the ward. The ward managers told us they had access to leadership and management training.
- Doctors told us that senior medical staff were accessible and they received good support.
- During our inspection we observed positive working relationships within all teams.
- 31% of staff who participated in the NHS staff survey reported good communication from senior management to staff; this was the same as the 2014 national average.

Culture within the service

- Staff said there was a positive, open and honest culture across at the hospital. Staff understood the need for openness and transparency and were knowledgeable about duty of candour.
- Staff said they felt supported and able to speak up to their immediate manager if they had concerns. Some staff felt frustrated by the staffing levels which affected their morale but felt they worked hard and were valued by their peers.
- In the 2015 staff survey results showed that the number of staff who felt motivated at work was similar to national average score of 3.94 with a score of 3.89. The number of staff who felt secure when reporting unsafe clinical practice was 3.59 which was also similar than the national average score of 3.62.
- Results of the 2015 NHS Staff survey showed the trust scored worse than the national average for effective team working and organisation and management interest in and action on staff health and wellbeing. The trust scored in line with the national average for the majority of indicators and performed better than average for three indicators related to the levels of bullying from both staff and patients and staff working extra hours. The trust performed in line with the national average for 23 indicators. However it was noted 14 out of the 23 indicators were worse than the previous survey results.

Public engagement

- The trust had a public and engagement strategy 2013 to 2016, which was readily available on the trust website.
- The trust told us that governors would regularly attend events such as the Preston Health Mela and the University of Central Lancashire's (UCLan) Science festival and engage with the community, feeding back any issues or concerns.
- The trust had a magazine called 'Trust matters' for members of the trust, however, this could be accessed by all members of the public on the internet.
- Board meeting minutes were available on the trust's website, along with dates of future public board meetings.
- The hospital participated in the NHS friends and family test, giving people who used services the opportunity to provide feedback about care and treatment. At the time of the inspection, 90% of patients would recommend the wards at the hospital to friends or a relative.

Staff engagement

- The hospital participated in the NHS friends and family test, giving staff the opportunity to speak out about their place of work. From July 2016 to September 2016, 75% of staff would recommend this hospital to friends and family in need of care /treatment and 60% would recommend it as place to work to friends and family. Following the results a staff action and engagement plan 2016-2018 was devised.
- In February 2016 the trust engaged with staff at events called 'big discussions', to gain further clarity and identify improvements around the top three positive and negatives themes identified following the survey.
- The trust celebrated those members of staff who had worked in the NHS for 25 years at annual Long Service Awards.
- The trust celebrated the achievements of staff at an annual event. At the last event, the falls prevention team won the 'safe' award for the support they offer to those patients at risk of falling.

Innovation, improvement and sustainability

- Since March 2016, the trust participated in delayed transfer of care (DTOC) Improvement Programme. The trust worked with health and social care services, along with NHS improvement in a 90 day improvement programme and achieved a reduction in the DTOC from

6% to 3.8%. Senior managers told us this had resulted in several improvements, including the implementation of a check list to meet the agreed criteria for a continuing health care assessment, which has reduced the amount of assessments performed in hospital, thus expediting decisions around place of discharge.

- The trust were currently trialling a system where a recently recruited nurse reviewed delayed discharges and medical outliers on a daily basis, to identify any actions that can be taken the same day to facilitate discharge. Senior managers told us they felt this had contributed to the reduction in medical outliers trust wide.

Surgery

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

Information about the service

Royal Preston Hospital provides a range of surgical services, including trauma and orthopaedics, oral and maxilla-facial surgery, ear, nose and throat (ENT) surgery, breast surgery, ophthalmology, plastic surgery and general surgery (such as colorectal and upper gastro-intestinal (GI) surgery).

The hospital is the regional centre for vascular surgery, neurosurgery, burns and the major trauma centre for Lancashire and South Cumbria.

The hospital has 14 surgical wards with approximately 290 inpatient surgical beds. There are 15 operating theatres that carry out emergency trauma and general surgery as well as some day case and elective surgery procedures. The hospital also has separate day case unit with four theatres and the Charles Beard theatre unit (for burns and plastic surgery).

There were 30,416 surgical procedures carried out at the hospital between March 2015 and February 2016 and approximately 55% of patients had day surgery, 20% had elective surgery and 25% were emergency surgical patients.

We visited Royal Preston Hospital as part of our announced inspection during 27 to 30 September 2016. We also carried out an unannounced visit on 14 October 2016. As part of the inspection, we visited the surgical wards, theatre areas and the day case areas.

We spoke with nine patients. We observed care and treatment and looked at 11 care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, healthcare assistants, the matrons for surgery and theatres, theatres staff, business unit managers, the divisional medical director for surgery, the divisional head of nursing for surgery and the divisional directors for the surgical division and the diagnostics and clinical support division. We received comments from people who contacted us to tell us about their experiences. We reviewed performance information about the trust.

Surgery

Summary of findings

The surgical services were previously rated as requires improvement for safe, responsive and well-led in November 2014 following our last inspection. This was because we had concerns around staffing levels, mandatory training compliance and poor compliance against 18 week referral to treatment standards. At this inspection we rated the surgical services at the Royal Preston Hospital an overall rating of Requires improvement. This was because: -

- During this inspection, we found that although some improvements had been made, there were still areas where further improvement was needed.
- Most staff had completed mandatory training. However, less than 50% of staff had completed adult safeguarding training and the proportion of staff that had completed adult and paediatric life support training was below the hospitals expected levels.
- Most staff had completed their annual appraisals (71%), but the hospitals internal target for 82% appraisal completion had not been achieved.
- Most clinical areas were clean and well maintained. However, we found some theatre areas were aged and displayed signs of wear and tear. We saw areas with peeled and cracked paint on walls and where the walls around doorways were scuffed and showed slight impact damage. There was no scheduled refurbishment programme in place to upgrade or refurbish the theatre areas in the near future.
- The national early warning score system (NEWS) audit from May 2016 showed a patient monitoring plan was completed and followed on 46% of occasions and patients were appropriately escalated on 48% of occasions. This meant there was a potential risk that deteriorating patients may not receive timely care and support.
- The surgical wards did not have sufficient numbers of substantive trained nursing and support staff. Staffing levels were maintained through the use of bank and agency staff and through the daily management and deployment of the existing staff.
- A recruitment programme was underway and a number of nursing and healthcare assistant posts had been appointed. However, the majority of nursing recruits were newly qualified staff and were scheduled to commence employment between January 2017 and March 2017.
- The services performed worse than the England average for 18 week referral to treatment (RTT) waiting times between August 2015 and June 2016 for most surgical specialties. There was a worsening trend in performance which meant the number of patients waiting longer than 18 weeks for treatment had steadily increased since the start of 2016.
- As part of the surgical division RTT recovery plan, a review identified seven specialty areas with an imbalance in capacity and demand that would lead to increasing waiting lists. The recovery plan included actions to improve 18 week wait times and to improve patient flow and efficiency in the wards and theatres by March 2017.
- The proportion of elective patients whose operations were cancelled and were not treated within the 28 days across the trust was significantly worse that the England average between July 2014 and June 2016. There were 221 patients whose operations were cancelled and were not treated within the 28 days during this period.
- Performance shortfalls were reported on monthly performance dashboards and routinely reviewed at departmental and divisional meetings. However, the services had failed to implement timely and effective remedial actions to address these issues in order to improve the services.
- A new divisional structure had been in place since December 2015 and most staff felt this was a significant improvement from the previous organisational structure. However, the governance and performance reporting systems were still being imbedded as a result of personnel changes and new reporting structures.

However;

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately.

Surgery

- Patients spoke positively about the care and treatment they received. Patient feedback from the NHS Friends and Family Test showed that most patients were positive about recommending the surgical wards to friends and family.
- The services participated in national and local clinical audits and performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures.
- There was effective teamwork and visible local leadership within the services. Staff were positive about the culture within the surgical services and there was routine public and staff engagement.

Are surgery services safe?

Requires improvement

At the previous inspection in July 2014 we rated safe as requires improvement due to staffing levels, mandatory training compliance and the management of equipment, we have maintained this rating following this inspection. This is because:

- The proportion of staff that had completed life support training and safeguarding training (for adults and children) was below the hospitals expected levels. For example, less than 50% of staff had completed adult and children's safeguarding training.
- We found that only 19% of medical staff in the surgery business unit and 46% of medical staff in the trauma business unit had completed advanced life support (ALS) training, compared with the hospital target of 90% training completion. Only 54% of staff across the surgical services had completed adult basic life support (ABLS), compared to the target of 90% compliance.
- The main theatres and the Charles Beard theatres were clean but some sections were aged and displayed signs of wear and tear. For example, we saw areas with peeled and cracked paint on walls and where the walls around doorways were scuffed and showed slight impact damage. There was a schedule in place to repaint and refurbish the surgical wards and theatres by March 2017.
- The national early warning score system (NEWS) audit from May 2016 showed a patient monitoring plan was completed and followed on 46% of occasions and patients were appropriately escalated on 48% of occasions. The services planned to improve compliance through increased monitoring and training for staff.
- The surgical wards did not have sufficient numbers of substantive trained nursing and support staff. There were approximately 44 nursing staff and seven support staff vacancies during August 2016.
- A recruitment programme was underway and 33 nursing and 16 healthcare assistants were pending appointment by October 2016. However, the majority of nursing recruits were newly qualified staff and were not scheduled to commence employment until January to March 2017.

- The ward managers were able to maintain safe staffing levels through bank and agency staff usage, by increasing care staff on shifts with nurse shortfalls and by transferring staff to wards with higher patient dependency levels.
- Records for September 2016 showed the average shift fill rate for nursing staff across the surgical wards was 85% during the day shift and 92% during the night shift. However, we found there were shortfalls in the nursing staff day shift on neurosurgery wards 2a and 2b (75% average fill rate) and urology ward 11 (78% average fill rate) during September 2016.

However, we also found that: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately.
- There were sufficient numbers of consultants and medical staff to provide patients with safe care and treatment.

Incidents

- There were no never events reported in relation to the surgical services at the hospital between August 2015 and August 2016. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.
- The Strategic Executive Information System (StEIS) data showed there were four serious patient safety incidents reported by the surgical services between August 2015 and August 2016. This included two instances of slips, trips and falls, one pressure ulcer incident and an allegation of abuse of adult patient by staff.
- We saw evidence to show these incidents were investigated and remedial actions were implemented to improve patient care.
- Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated by ward and theatre managers to look for improvements to the service. Serious incidents were investigated by senior staff with the appropriate level of seniority, such as the matrons or clinical leads.
- Staff told us they received verbal feedback about incidents reported and that this was used to improve practice and the service to patients. Incidents and complaints were discussed during daily safety huddles and monthly staff meetings so shared learning could take place. Learning from incidents was also shared through hospital-wide newsletters.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. The incident reporting system also provided prompts for staff to apply duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Patient deaths were reviewed by individual consultants. These were also presented and reviewed during monthly mortality and morbidity meetings and divisional clinical audit and effectiveness meetings every three months.

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, blood clots, catheter and urinary infections).
- Safety Thermometer information between July 2015 and July 2016 showed there were 33 pressure ulcers, eight falls with harm and 26 catheter urinary tract infections reported across the surgical services.
- Patient records showed that appropriate risk assessments were carried out upon admission to the wards and patients identified at risk had the appropriate care plans and supporting equipment (e.g. increased observations, pressure relieving mattresses) in place to minimise the risk of patient harm.
- Staff monitored compliance against recognised quality standards by carrying out monthly audits as part of the hospitals essentials of care audit programme (ECAP). The ECAP audit results showed the hospitals internal target (95% compliance) for falls prevention and management was achieved each month between March 2016 and July 2016.
- The monthly ECAP audit results for tissue viability ranged between 91.2% and 97.8% during this period which meant the 95% target compliance was not consistently achieved. The surgical services launched

the under pressure campaign in April 2016 to reduce pressure ulcers. The trust reported that the occurrence avoidable pressure ulcers had reduced by a third in the three months after the campaign commenced.
- We saw that notice boards near the entrance to ward areas displayed the number of patients with falls, pressure ulcers and CUTIs during the current month.

Cleanliness, infection control and hygiene

- There had been no MRSA bacteraemia infections and 10 Clostridium difficile (C. diff) infections relating to surgery across the trust between April 2016 and October 2016. The rate of C.diff infections was within the surgery divisions internal target (12).
- We looked at the investigation report and actions plans for two C.diff incidents that occurred in April 2016 and July 2016. These were investigated appropriately and there was clear involvement from nursing and clinical staff, as well as the hospitals infection control team.
- The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. However, we saw that clinical waste bags in the theatres were not clearly labelled in accordance with the Association for Perioperative Practice (AfPP) guidelines. The AfPP guidelines state that clinical waste bags should be labelled with the patients number, date of operation and theatre identity.
- There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance. Visitors were encouraged to wash their hands.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.
- Patients identified with an infection were isolated in side rooms. We saw that appropriate signage was used to protect staff and visitors.
- A monthly hand hygiene audit was carried out across the wards and theatre areas. Audit results from April 2016 and September 2016 showed high levels of compliance by staff and the ward and theatre areas consistently achieved the hospitals internal target of 95% compliance. Where hand hygiene issues were identified this was discussed with individual staff members to improve compliance.
- Infection control audits to check the cleanliness of the general environment and equipment took place fortnightly across the wards and weekly across the theatre areas. Audit results between January 2016 and August 2016 showed average compliance ranged between 96.5 % and 99.4%. This was better than the hospitals target of 92% to 97% compliance.
- Where cleanliness issues were identifies, remedial actions were put in place and these were followed up to minimise the risk of spread of infection.

Environment and equipment

- The general environment across the hospital was aged and worn but the wards we inspected were clean and in a good state of repair. The majority of clean utility rooms across the surgical wards had been recently refurbished.
- All the ward areas had sufficient shower and bathing facilities and separate male and female toilets were in place.
- All the theatre areas were free from clutter and we saw that equipment and consumable items were stored appropriately.
- The general environment within main theatres and the Charles Beard theatres was aged and showed signs of wear and tear. For example, we saw sections of the walls in theatres three and five (main theatres) where the paint had peeled and cracked. We also saw areas where the walls around doorways were scuffed and shown slight impact damage. We also saw that sections of the floor area outside the Charles Beard theatres were damaged and had been sealed with tape.
- The wear and tear of the general environment within the theatres areas meant there was a potential infection control risk because the sections with cracks or exposed plaster may not be appropriately cleaned or decontaminated.
- There was a schedule in place to repaint and refurbish the surgical wards and theatres by March 2017.
- Equipment was appropriately checked and cleaned regularly and the majority of equipment we saw had service stickers displayed and these were within date. Single-use, sterile instruments were stored appropriately and were within their expiry dates.

- Equipment needed for surgery was readily available and any faulty equipment could be replaced from the hospitals equipment store.
- Equipment was serviced by the trusts maintenance team under a planned preventive maintenance schedule. Staff told us they received good and timely support.
- The ventilation systems in the theatre areas had been services and validated within the past 12 months in line with Health Technical Memorandum HTM 03-01: Specialised ventilation for healthcare premises.
- Reusable surgical instruments were sterilised in a dedicated sterilisation unit at Chorley and South Ribble Hospital. Theatre staff told us they did not have any concerns relating to the sterilisation or availability of surgical instruments used for surgery.
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff. The hospital may wish to note that none of the emergency (crash) trolleys we saw were locked even though they contained items such as intravenous fluid (saline) bags. There is a potential risk that these items could be tampered with. This was raised with the trust at the inspection and appropriate action was taken.

Medicines

- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly. Staff were supported by pharmacy technicians during weekdays.
- We found that medicines were ordered, stored and discarded safely and appropriately.
- We saw that medicines that required storage at temperatures between 0C and 8C were appropriately stored in medicine fridges. Fridge temperatures were checked daily and medicines were stored at the correct temperatures.
- We saw evidence that staff had notified the maintenance team and the pharmacy department where fridge temperatures exceeded the maximum temperature range.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff we spoke with confirmed a pharmacist carried out daily reviews on each ward.
- We looked at nine sets of medication records. Patients were given their medicines in a timely way, as prescribed, and records were completed appropriately. However, there were some errors / omissions in the records, such as missing signatures.
- The medication records also showed patients that received oxygen treatment had oxygen prescribed and appropriately documented.
- The ECAP audit results showed the hospitals internal target (95% compliance) for medication administration and prescribing was achieved each month between March 2016 and July 2016.

Records

- Staff used paper patient records and these were securely stored in each area we inspected.
- Staff also used an electronic system for recording risk assessments, such as for falls, venous thromboembolism (VTE blood clots), pressure care and nutrition and these were reviewed and updated on a regular basis.
- We looked at the records for 11 patients. These were structured, legible, complete and up to date.
- Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly.
- Standardised nursing documentation was kept at the end of patients beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.
- The ECAP audit results showed the hospitals internal target (95% compliance) for patient observations and completion of VTE risk assessments was achieved between March 2016 and July 2016.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children.
- Records showed 46% of staff across the surgical services had completed safeguarding adults (level 2) training and 49% had completed had completed safeguarding adults (level 3) training. This was below the hospitals internal target of 75% training completion.
- Records showed 94% of staff across the surgical services had completed child protection awareness training.

However, only 45% of staff had completed child protection (level 1) training and 79% had completed child protection (level 3) training. This was below the target of 90% training completion.

- The staff we spoke with were aware of how to identify abuse and report safeguarding concerns. Information on how to report adult and childrens safeguarding concerns was displayed in the areas we inspected. Each area also had safeguarding link nurses in place.
- Staff were aware they could seek advice and support from the hospital-wide safeguarding team.
- Safeguarding incidents were reviewed by the departmental managers and also by the trust-wide safeguarding group, which held meetings every two months to review individual incidents and to look for trends.

Mandatory training

- Staff received mandatory training in key areas such as fire safety, health and safety, resuscitation, infection control, information governance, moving and handling, information governance and safeguarding of vulnerable adults and child protection.
- Mandatory training was delivered on a rolling programme and monitored on a monthly basis. The training was delivered either face-to-face or via e-learning.
- Records up to July 2016 showed that overall mandatory training compliance for staff across the surgical services was 81% and the hospitals internal target of 80% had been achieved.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues and there was daily involvement by ward managers and matrons to address these risks.
- On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism, pressure ulcers, nutritional needs, risk of falls and infection control risks.
- Patients at high risk were placed on care pathways and care plans were put in place so they received the right level of care. Staff carried out intentional rounding observations so any changes to the patients medical condition could be promptly identified.
- Staff used national early warning score systems (NEWS) and carried out routine monitoring based on patients individual needs to ensure any changes to their medical condition could be promptly identified.
- A NEWS audit was completed in May 2016 and the findings were based on a review 137 records across the surgical wards at the hospital. The audit showed good staff compliance in three of the five audit standards; all information completed (86%), vital signs recorded correctly (82%) and NEWS calculated accurately (80%).
- The audit also showed further improvements were needed for the remaining two standards; monitoring plan completed and followed (46%) and patients appropriately escalated (48%, based on 12 out of 25 applicable patients).
- The NEWS audit report listed a number of actions to further improve compliance, including raising awareness and training for staff to recognise and escalate NEWS concerns and monitoring of staff compliance by the matrons and ward managers.
- We observed seven theatre teams undertaking the five steps to safer surgery procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the five steps to safer surgery procedures.
- The WHO checklist audit for the period between January and June 2016 involved a review of 27 completed checklist records. The audit report showed high levels of staff compliance in the use of the checklist (97% to 100%).

Nursing staffing

- Nurse staffing levels were reviewed against minimum compliance standards, based on national NHS safe staffing guidelines. The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- The theatre areas had sufficient numbers of trained nursing and support staff with an appropriate skill mix. The theatre staffing levels were based on nationally recognised guidelines such as the Association for Perioperative Practice (AfPP). The matron for theatres told us they rarely used external agency staff and cover was provided by the existing staff working additional hours.

- Records up to August 2016 showed the vacancy rate across the surgical wards was approximately 10% (equivalent to 44 staff) for nursing staff and 7% (seven staff) for support staff.
- The nursing and midwifery staffing and skill mix report from November 2016 identified there were 34 nursing and healthcare assistant vacancies across the surgical division.
- Recruitment for vacant posts was on-going. Records up to October 2016 showed 33 nursing posts, 16 healthcare assistant (HCA) posts and seven senior HCA posts had been recruited to across the surgical division and were awaiting commencement of employment. The majority of appointed nursing posts were for newly qualified nurses with scheduled start dates between January 2017 and March 2017.
- There were also an additional 20 nursing posts and seven HCA posts that were at various stages of recruitment during October 2016.
- Records for September 2016 showed the average shift fill rate for nursing staff across the surgical wards was 85% during the day shift and 92% during the night shift. There were shortfalls in the nursing staff day shift on neurosurgery wards 2a and 2b (75% fill rate) and urology ward 11 (78% fill rate) during September 2016.
- The matrons and ward managers carried out daily staff monitoring and escalated staffing shortfalls due to vacancies, unplanned sickness or leave. Staffing levels were maintained through the use of bank and agency staff and by existing staff working additional hours.
- The ward managers told us they increased the numbers of care staff on shifts with nursing staffing shortfalls in order to provide safe care and meet the acuity (dependency) needs of patients. Records for September 2016 showed shift fill rates for care staff ranged between 125% and 113% across the surgical wards.
- Staff from surgical wards with lower dependency levels were also temporarily transferred to wards (within the same surgical speciality) where there was a shortfall in staff numbers or an increase in patient dependency levels.
- The ward managers told us staffing levels were based on the dependency of patients and this was reviewed daily. We saw that patients with greater dependency following their surgery were provided with 1:1 care across the surgical wards.
- Nursing staff handovers took place during daily shift changes and these included discussions about patient needs and any staffing or capacity issues. Patients spoke positively about the staff and did not highlight any concerns relating to nurse staffing levels.

Surgical staffing

- The wards and theatres we inspected had sufficient numbers of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The proportion of consultants, middle career, registrar group and junior doctors was similar to the England average.
- The divisional medical director for surgery told us the majority of consultant and middle grade posts were fully recruited to. Records showed there were eight consultant vacancies (including two consultant posts in each of the orthopaedic, neurosurgery and ophthalmology specialties). There were also eight specialty and associate specialist (SAS) doctor posts vacant. Recruitment for these posts was on-going and six consultants had recently been appointed across the services with confirmed start dates between November 2016 and March 2017.
- Separate medical staffing rotas were in place for each surgical speciality. We found there was sufficient on-call consultant cover over a 24-hour period and there was sufficient medical cover outside of normal working hours and at weekends.
- The orthopaedic and vascular specialties had a consultant of the week model where consultants were free from other clinical duties during the day to ensure they were available when needed. At times some on-call consultants within the vascular, neurosurgery and plastics specialties would not be on site for the whole day if they had clinics running at the trusts other sites.
- Staff rotas showed there was sufficient on-site junior and middle grade medical cover across each specialty over a 24-hour period.
- Across the surgical specialties there were 20 junior doctor vacancies (including 12 from the deanery). The divisional medical director told us the number of junior doctors supplied by the deanery had been reduced. The medical director planned to start an overseas doctor recruit programme during early 2017 to address the shortfalls.

- Staff rotas were maintained by the existing staff and through the use of agency or locum consultants. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospitals policies and procedures.
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs. Junior and middle grade doctors told us they received good support and could easily access the on-call consultant if needed.

Major incident awareness and training

- There was a documented major incident plan in place and this listed key risks that could affect the provision of care and treatment. Surgical staff were aware of how to access this information when needed.
- There were clear instructions for staff to follow in the event of a fire or other major incident. Staff also had guidelines in place for dealing with medical emergencies such as a patient going into cardiac arrest.
- Records showed 100% of medical staff and 50% of support staff across the theatres and outpatients clinical business unit had completed advanced life support (ALS) training.
- The proportion of medical staff that had completed ALS training in the surgery business unit (19%) and trauma business unit (46%) was below the hospital target of 90% training completion.
- The information supplied by the trust did not clearly show if any nursing staff across the surgical services had completed ALS training. The records also showed none of the nursing or medical staff across the surgical services had completed advanced paediatric life support (APLS) training.
- Records for all staff across the surgical services also showed that: -
  - 53% of staff had completed immediate life support (ILS), which was below the hospitals internal target of 85% compliance.
  - 54% of staff had completed adult basic life support (ABLS), compared to the target of 90% compliance.
  - 23% of staff had completed paediatric immediate life support (PILS), compared to the target of 90% compliance.
  - 38% of staff had completed paediatric basic life support (PBLS), compared with a target of 65% compliance.

Are surgery services effective?

Good

At the previous inspection in July 2014 we rated effective as good, we have maintained this rating following this inspection because:

- The services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits.
- The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures. Where these standards had not been achieved, actions had been taken to improve audit compliance.
- Most surgical specialties performed in line with the England average for average length of patient stay and for the proportion of patients readmitted to the hospital following discharge. Actions were being taken to improve the surgical specialties where length of stay and readmission rates were higher than expected, such as for acute biliary (gallstone) patients.
- The proportion of patients readmitted to the hospital following discharge was 7.38% compared with the target of 7.39% and no clinical concerns had been raised relating to readmission rates. One of the challenges in relation to readmissions for acute biliary (gallstone) patients. Actions were being taken to improve areas where readmission rates were higher than expected, such as for acute biliary (gallstone) patients.
- Patients received care and treatment by appropriately qualified and competent staff that worked well as part of a multidisciplinary team.
- Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.

However;

- Most staff had completed their annual appraisals (71%), but the hospitals internal target for 82% appraisal completion had not been achieved.

Surgery

Evidence-based care and treatment

- Clinical audits included monitoring of National Institute for Health and Care Excellence (NICE). Emergency surgery was managed in accordance with the National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations and the Royal College of Surgeons standards for emergency surgery.
- Staff provided care in line with Recognition of and response to acute illness in adults in hospital (NICE clinical guideline 50) and Rehabilitation after critical illness (NICE clinical guideline G83).
- Enhanced recovery pathways were used in a number of surgical specialities, such as fractured neck of femur (hip) surgery. Enhanced recovery is a modern, evidence-based approach that helps people recover more quickly after having major surgery.
- During 2015/16 the trust participated in all the national clinical audits and national confidential enquiries relating to surgical services for which it was eligible to participate in. The clinical audit and effectiveness forward programme (April 2016 to March 2017) listed all the local and national clinical audits the surgical services were currently involved in.
- Findings from clinical audits were reviewed during routine clinical audit and effectiveness meetings and any changes to guidance and the impact that it would have on their practice was discussed.
- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trusts intranet. We looked at a selection of the hospitals policies and procedures and these were up to date and reflected national guidelines.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.
- The monthly essentials of care audit programme (ECAP) audit results for pain management average score was 99.6% between March 2016 and July 2016. This meant the hospitals 95% target for compliance was consistently achieved during this period.
- The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort. Patients told us staff gave them pain relief medication when needed and their pain symptoms were managed appropriately.
- There was a dedicated pain team within the hospital and staff knew how to contact them for advice about treatment when required.

Nutrition and hydration

- Patient records included assessments of patients nutritional requirements. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- The monthly ECAP nutritional management audit average score was 97% between March 2016 and July 2016. This meant the hospitals 95% target for compliance was consistently achieved during this period.
- Patient records showed fluid balance charts were in place and these were complete and up to date. The records also showed that there was regular dietician involvement with patients who were identified as being at risk.
- Patients with difficulties eating and drinking were placed on special diets. We also saw that the surgical wards used a coloured tray system so patients requiring assistance could be identified and supported by staff during mealtimes.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.

Patient outcomes

- The national hip fracture audit 2015 showed that the hospital performed better than the England average for all six indicators. This included case ascertainment, patient length of stay, perioperative medical assessment rate, risk-adjusted 30-day mortality rate and the number of patients having surgery on the day or day after admission to the hospital.
- The national vascular audit 2015 showed the hospital scored better than the aspirational 90% standard for case ascertainment rate (for abdominal aortic aneurysm procedures). The hospital also performed within the expected range for risk-adjusted mortality rates.

- The vascular audit showed the hospital (28 days) scored worse than the aspirational 14-day standard for median time from symptom to surgery for carotid endarterectomy (procedure to unblock a carotid artery).
- The national oesophago-gastric cancer audit 2015 showed the hospital was better than the national average for case ascertainment and the proportion of patients treated with curative intent. The hospital also performed within the expected range for risk-adjusted 90-day post-operative mortality rate.
- The national bowel cancer audit of 2015 showed that the hospital performed better than the national average for post-operative length of stay greater than five days after major resection. The hospital was within expected ranges for risk-adjusted 90-day post-operative mortality rate and risk-adjusted 90-day unplanned readmission rate.
- The bowel cancer audit also showed the hospital performed below the national average and was rated fair for case ascertainment rate and data completeness. The hospital also performed worse than the average for risk-adjusted 18-month temporary stoma rate in rectal patients undergoing major resection (70% compared to average of 50%).
- The divisional Medical Director for surgery reported that the records for the 68 patients (70%) identified in the audit has still having a stoma 18 months after a rectal cancer resection had been reviewed.
- The review showed that 65 of these patients had delayed or non-closure of stomas at 18 months due to valid clinical reasons or reasons of patient preference. Two patients had chemotherapy and required recovery time following this before committing to further surgery and all of the patients identified in the audit had stoma closure within 20 months.
- The national emergency laparotomy audit (NELA) 2015 showed that the hospital achieved green (70-100%) compliance for two of the 10 standards; case ascertainment and arrival in theatre in timescale appropriate to urgency. The hospital achieved amber (50-69%) compliance for six out of the 10 standards and achieved red (0-49%) compliance for the remaining three standards; risk documented pre-operatively, pre-operative review by consultant surgeon and anaesthetist and assessment by a medicine for care of the older person (MCOP) specialist in patients over 70 years of age.
- There was an action plan in place to improve against the NELA standards that had not been fully achieved, such as increasing consultant presence in theatres, improving the time taken for computed tomography (CT) scans and increasing the availability of elderly care doctors.
- Performance reported outcomes measures (PROMs) data between April 2015 and March 2016 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement and knee replacement was similar to the England average.
- The proportion of patients with improved outcomes following varicose vein procedures was much better than the England average during this period, with fewer patients reporting a worsening and more patients reporting an improvement after treatment, compared to the national average.
- The number of patients that had elective and non-elective surgery and were readmitted to hospital following discharge was worse than the expected range for all specialties except for elective neurosurgery.
- The trust reported that overall readmission rates were 7.38% compared with the internal trust target of 7.39% and no clinical concerns had been raised relating to readmission rates. One of the challenges in relation to readmissions was acute biliary (gallstone) patients who were treated then discharged and added to an elective waiting list. Due to the waiting time for this procedure patients were sometimes readmitted when symptoms reoccurred. The trust planned to improve this by opening a second emergency theatre at this hospital.
- The divisional medical director for surgery also told us a review was underway to determine if there were any data quality or coding issues in relation to the reporting of patient readmission rates.
- Actions taken to improve patient readmission rates included an increased focus on consultant reviews to reduce the risk of readmission and the implementation of a hot clinic in general surgery which enabled consultants to discharge patients with the option of an urgent review in the hot clinic if required.

Competent staff

- Newly appointed staff had an induction and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.

- The theatres department had a practice educator that oversaw training processes and carried out competency assessments based on national competency guidelines.
- Staff told us they routinely received supervision and annual appraisals. Records up to July 2016 showed the majority of staff across the division of surgery (71%) had completed appraisals. However, this was below the hospitals internal target of 82% appraisal completion.
- Records showed most eligible medical staff in the surgical services that had reached their General Medical Council revalidation date had been reviewed within the recommended time scale or had a planned review date in place. There were only three overdue reviews from the 180 doctors in the surgical division.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and safety huddles were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- The ward staff told us they had a good relationship with consultants and ward-based doctors.
- Specialty multidisciplinary (MDT) meetings took place on a weekly basis with input from medical and nursing staff as well as medical staff from other hospitals where patients received care and treatment from more than one healthcare organisation.
- We observed the colorectal specialty MDT during the inspection. The meeting had input from oncology, pathology, surgery and nurse specialists and all aspects of the patients care needs were discussed.
- There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals.
- The ward and theatre staff told us they received good support from pharmacists, dieticians, physiotherapists, as well as diagnostic support such as for x-rays and scans.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover.
- At weekends, newly admitted patients across most specialities were seen by a consultant, and existing patients were seen by the ward-based doctors. However, patients admitted to neurosurgery on weekends were sometimes seen by a registrar and not a consultant.
- There was a 24-hour service with dedicated emergency and trauma theatres so any patients admitted over the weekend that required emergency surgery could be operated on promptly.
- Microbiology, imaging (e.g. x-rays), physiotherapy, occupational therapy and pharmacy support was available on-call outside of normal working hours and at weekends. The pharmacy was also open for a limited number of hours on Saturdays and Sundays. Staff could also access an emergency drugs cupboard if needed during out-of-hours or on weekends.
- The ward and theatre staff told us they received good support outside normal working hours and at weekends.

Access to information

- We saw that information such as audit results, performance information and internal correspondence were displayed in all the areas we inspected. Theatre staff used visual in-brief boards to aid planning. Ward staff also used visual boards to identify patients with specific needs, such as patients living with dementia or at risk of falls.
- Staff used pre-printed care pathway booklets for individual procedures, such as for fractured neck of femur (hip) surgery, and these were version-controlled and readily available.
- Staff could access information such as policies and procedures from the hospitals intranet. Staff told us they could access up to date national best practice guidelines and prescribing formularies when needed.
- The hospital used paper based patient records that contained detailed patient information from admission

and surgery through to discharge. Risk assessments (such as VTE, pressure care and nutrition) were recorded on an electronic system that was accessible by staff and provided an audit trail for monitoring and audit purposes. The staff we spoke with told us they could access all the information needed about the patient at any time.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Patient records showed that consent had been obtained from patients or their representatives and that planned care was delivered with their agreement.
- Consent records showed the risks and benefits of the specified surgical procedure were clearly documented and had been explained to the patient.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative) that could legally make decisions on the patients behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patients representatives and other healthcare professionals. We saw evidence of this in the patient records we looked at.
- Patient records showed that staff carried out mental capacity assessments for patients thought to lack capacity to make an informed decision about their treatment. We looked at two patient records where a DoLS application had been made and the records for this had been completed correctly.
- There was a hospital-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and DoLS applications.

Are surgery services caring?

Good

At the previous inspection in July 2014 we rated caring as good, we have maintained this rating following this inspection because:

- We spoke with nine patients. They all spoke positively about the care and treatment they received. They told us they were treated with dignity and compassion and their privacy was respected.
- Patients and their relatives were kept fully involved in their care and the staff supported them with their emotional and spiritual needs.
- Patient feedback from the NHS Friends and Family Test between July 2015 and June 2016 showed most surgical wards consistently scored above 90%. This showed that most patients were positive about recommending the surgical services to friends and family.

Compassionate care

- We saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner in the wards and theatre areas.
- Patients bed curtains were drawn when providing care and treatment and staff spoke with patients in private to maintain confidentiality.
- Patients could also be transferred to side rooms to provide privacy and to respect their dignity. The privacy and dignity of patients being transferred to the theatre areas was maintained and patients were provided with gowns and blankets. However, we identified a patient in theatres who was not provided with disposable underwear and this had an impact on their privacy and dignity.
- We spoke with nine patients. They all told us they thought staff were friendly and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included: "staff very good, friendly, supportive", "nurses are very good" and "the care couldn't have been better".

- The NHS Friends and Family Test is a satisfaction survey that measures patients satisfaction with the healthcare they have received. The test data between July 2015 and June 2016 showed the majority of surgical wards consistently scored above 90%.
- The average scores across the services were below the England average during this period. However, the survey showed the majority of patients were positive about recommending the hospitals surgical wards to friends and family.
- The average response rate (the percentage of patients that completed the survey out of all eligible patients) was better than the England average of 30% across all the surgical wards.
- The CQCs adult inpatient survey 2015 showed the trust was rated 'about the same' when compared with other trusts for all 10 sections, based on 501 responses received from patients.

Understanding and involvement of patients and those close to them

- Staff respected patients rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- Patient records included pre-admission and pre-operative assessments that took into account individual patient preferences. Staff were respectful and sought permission from patients before they delivered care or treatment.
- Patients told us they were kept informed about their treatment. They spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions.

Emotional support

- The staff we spoke with understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to patients.
- Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties. Patients told us the anaesthetists and surgeons were calm and reassuring. One patient commented that the staff lift you up and make you feel better.
- Staff told us they could contact the hospitals palliative (end of life) care team for support and advice during bereavement.

Are surgery services responsive?

Requires improvement

At the previous inspection in July 2014 we rated responsive as requires improvement mainly due to concerns around the services performance against 18 week referral to treatment standards, we have maintained this rating following this inspection because:

- During this inspection, we found that no significant improvements had been made and further improvement was still needed.
- The services performed worse than the England average for 18 week referral to treatment (RTT) waiting times for admitted and non-admitted patients between August 2015 and June 2016 for most surgical specialties.
- There was a worsening trend in performance which meant the number of patients waiting longer than 18 weeks for treatment had steadily increased since the start of 2016.
- As part of the surgical division RTT recovery plan, a review identified seven specialty areas with an imbalance in capacity and demand that would lead to increasing waiting lists. The recovery plan included actions to improve 18 week wait times and to improve patient flow and efficiency in the wards and theatres by March 2017.
- There were 1,059 operations cancelled between October 2015 and September 2016. The most frequent reason for cancellations was ward bed unavailability. Bed occupancy levels were high (97.7%) and 208 medical patients were admitted to the surgical wards between January 2016 and July 2016.
- The average bed occupancy rate across the surgical division between April 2016 and July 2016 was 97.7%, compared with the trust target of 85%. This was reflected in the surgical wards we visited as we found that most available beds were occupied.

- The main theatres had 15 operating theatres with a recovery area with 10 beds. This meant that theatre usage could be limited by the number of available recovery beds. There was a plan to enlarge the recovery area to free up capacity for up to eight additional recovery beds. However, there was no formal timeline for when this was likely to take place.
- The theatre recovery area was also used as an escalation area for critical care or for the stabilisation of patients from other parts of the hospital. There were nine instances where non- theatre surgical patients were kept in the main theatres recovery area between August and September 2016. This included three instances where patients were kept overnight.
- The proportion of elective patients whose operations were cancelled and were not treated within the 28 days across the trust was significantly worse that the England average between July 2014 and June 2016. There were 221 patients whose operations were cancelled and were not treated within the 28 days across the trust during this period.

However;

- There were systems in place to support vulnerable patients. Most complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

Service planning and delivery to meet the needs of local people

- Hospital episode statistics data showed 30,416 surgical procedures took place at the hospital between March 2015 and February 2016. The data showed that approximately 55% of patients had day case procedures, 20% had elective surgery and 25% were emergency surgical patients.
- The hospital provided a range of elective and unplanned surgical services for the communities it served. This included trauma and orthopaedics, oral and maxilla-facial surgery, ear, nose and throat (ENT) surgery, breast surgery, ophthalmology, plastic surgery and general surgery (such as colorectal and upper gastro-intestinal (GI) surgery).
- The trust was the regional centre for vascular surgery, neurosurgery, burns and the major trauma centre for Lancashire and South Cumbria.
- There were arrangements in place with neighbouring hospitals to allow the transfer of patients for surgical specialties not provided by the hospital, such as cardiothoracic surgery.
- The ward and theatre areas we inspected were compliant with same-sex accommodation guidelines.
- There were daily meetings with the bed management team so patient flow could be maintained when possible and to identify and resolve any issues relating to the admission or discharge of patients.
- There was a 'hot clinic' in place where non-emergency surgical admissions (such as general practitioner referrals) were seen by an assistant practitioner and a surgical doctor. The hot clinic reviewed patients to determine whether they could be treated and discharged without being admitted to the ward areas.
- A major trauma unit with 10 inpatient beds was opened in 2016. This was a high observation area where patients with life or limb threatening injuries received specialist care with support from dedicated trauma nurses.

Access and flow

- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via GP referral.
- Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.
- Staff completed a discharge checklist, which covered areas such as medication and communication to the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner. Discharge letters written by the doctors included all the relevant clinical information relating to the patients stay at the hospital.
- The average bed occupancy rate across the surgical division between April 2016 and July 2016 was 97.7%, compared with the trust target of 85%. This was reflected in the surgical wards we visited as we found that most available beds were occupied.
- We did not see significant numbers of medical patients admitted to the surgical wards (medical outliers) during the inspection. Records showed that between January 2016 and July 2016 showed there were a total of 208 patients that were medical outliers across the 10 surgical-specialty wards. Staff on the surgical wards told us medical outlier patients were seen daily by medical doctors.

Surgery

- The ward managers told us it was very rare for a surgical patient to be placed on a medical ward. However, there were instances where surgical patients were placed in another surgical specialty ward.
- The surgical consultants and doctors had a list of patients that were placed in other wards so these patients could be reviewed daily. Patient records showed that patients were reviewed by doctors from the relevant surgical specialty on a daily basis.
- The average patient length of stay was better than the England average for all specialties except elective neurosurgery and non-elective plastic surgery.
- The trust reported that the main reasons for increased patient stay in neurosurgery were due to complex patient conditions (e.g. head injuries or multi-trauma brain procedures) and delays in transferring (repatriating) patients back to the original hospital they were referred from.
- The main theatres had 15 operating theatres with a recovery area with 10 beds, including three dedicated paediatric beds. This meant that theatre usage could be limited by the number of available recovery beds, resulting in delayed or cancelled operations.
- The critical care services had an escalation area with four beds adjacent to the recovery area. The matron for theatres told us the critical care escalation area was a temporary measure and enlarging the recovery area would free up capacity for up to eight additional recovery beds. However, there was no formal timeline for when this was likely to take place.
- The theatre and critical care escalation policy outlined the contingency plans during busy periods and provided guidance for staff when the recovery area was used as an escalation area for critical care or for the stabilisation of patients from other parts of the hospital.
- Records showed there were nine instances where non-theatre surgical patients were kept in the main theatres recovery area during August and September 2016. This included three instances where patients were kept overnight.
- These patients received safe care and were supported by critical care staff from the adjacent critical care area. However, the matron for theatres told us the use of recovery beds for critical care escalation reduced the availability of recovery beds for surgical patients and lead to delayed or cancelled procedures.
- Records between May 2016 and July 2016 showed the average theatre utilisation (efficiency) across all the theatres was 90% compared to the hospitals aspirational target of 85% utilisation.
- There were 1,059 operations cancelled between October 2015 and September 2016. NHS England data showed there were no urgent operations cancelled during this period.
- The most frequent reasons for cancelled operations were 'no bed on ward' (44%) and 'overrun due to complications with previous patient' (14%).
- The proportion of cancelled operations as a percentage of elective admissions was higher (worse) than the England average between July 2014 and June 2016.
- The proportion of patients whose operations were cancelled and were not treated within the 28 days across the trust was significantly worse that the England average between July 2014 and June 2016. There were 221 patients whose operations were cancelled and were not treated within the 28 days during this period.
- There was a worsening trend as 104 of these cancellations (47%) took place between January and June 2016. The main reason was due to the unavailability of ward beds or critical care beds which meant the patients could not be operated on the day of surgery.
- NHS England data showed the trust performed worse than the England average for 18 week referral to treatment (RTT) waiting times for admitted patients between August 2015 and June 2016 for all surgical specialties except trauma and orthopaedics (77.6% compared with the average of 69.9%).
- Records showed consistently poor compliance in two specialties during this period: oral surgery (58.4% compared to average of 75%) and neurosurgery (55.6% compared to average of 76.2%).
- The incomplete referral to treatment waiting time standard is that at least 92% of patients should have to wait less than or equal to 18 weeks of referral for their treatment.
- Records showed that none of the eight specialties achieved the 92% standard during the period between February 2016 and August 2016. Prior to this period four of the eight surgical specialties (urology, orthopaedics, ophthalmology and ear, nose and throat) achieved the 92% incomplete pathway standard between September 2015 and January 2016.

- There was a worsening trend as overall compliance across the surgical specialties was 90% in September 2015 and this reduced month on month to 82% compliance in August 2016. This meant the number of patients waiting longer than 18 weeks for treatment had steadily increased during this period.
- As part of the surgical division RTT recovery plan, a review of the capability of services was carried out. This identified seven specialty areas with an imbalance in capacity and demand that would lead to increasing waiting lists.
- The recovery plan listed a broad range of actions to improve compliance with RTT standards. This included reducing the waiting list backlog, outsourcing or transferring services, recruitment of additional staff, a review of patient pathways and improving patient flow and efficiency in the wards and theatres.
- The recovery plan aimed to achieve compliance with RTT waiting times standards by April 2017. Progress against the proposed actions was scheduled to be monitored at specialty and divisional level meetings on a monthly basis.

Meeting people's individual needs

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- The areas we inspected had dementia link nurses in place. Staff also used a 'passport' document for patients admitted to the hospital with dementia or a learning disability. This was completed by the patient or their representatives and included key information such as the patients likes and dislikes. The ward staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.
- Staff could also contact the trust-wide safeguarding team for advice and support for caring for patients living with dementia or a learning disability.
- There were facilities within the hospital to allow relatives or carers of patients to stay overnight if needed.
- Staff could access appropriate equipment, such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.
- The recovery area in the main theatres could accommodate up to three paediatric patients. However, these were located within the main recovery area, which meant segregation was only maintained through the use of bed-side curtains.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the staff.
- The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team, who notified individual managers when complaints were overdue.
- Staff told us that information about complaints was discussed during daily safety huddles and at routine team meetings to aid future learning. We saw evidence of this in the meeting minutes we looked at.
- The hospitals complaints and concerns policy stated that complaints would be acknowledged within three working days and responded to within 25 working days for routine formal complaints or within 40 working days for complex complaints that required detailed investigation.
- There were 101 complaints raised in relation to surgery at the hospital between August 2015 and July 2016. The most frequent reasons for complaints were clinical treatment and communication.
- The average time taken to respond to these complaints was 65 days. This meant the majority of complaints about the surgical services were responded to in a timely manner, but not always within the timescales specified in the hospitals complaints policy.

Are surgery services well-led?

Requires improvement

At the previous inspection in July 2014 we rated well led as requires improvement mainly due to concerns about the overall management and effectiveness of the surgical services, we have maintained this rating following this inspection because:

- We identified shortfalls in staffing levels, mandatory training compliance and poor compliance against 18 week referral to treatment standards during this inspection. These concerns were also identified in 2014 following our previous inspection.
- This information had been reported on monthly performance dashboards and routinely reviewed at departmental and divisional meetings. However, the services had failed to implement timely and effective remedial actions to address these issues in order to improve the services.
- We had concerns around the timeliness and pace at which improvement actions were being put in place. We also found that performance in areas such as 18 week referral to treatment compliance had worsened during 2016. This meant we were not fully assured that the surgical services had effective clinical governance systems in place in order to continuously improve the quality of their services.
- A new divisional structure had been in place since December 2015. Most surgical services formed part of the surgical division, whereas the theatres formed part of the diagnostics and clinical support division.
- Most staff felt this was a significant improvement from the previous organisational structure and that there were routine meetings and collaborative teamwork across the two divisions. However, the governance and performance reporting systems in the new divisional structure were still being imbedded as a result of personnel changes and new reporting structures.

However;

- The hospitals values and corporate objectives had been cascaded across the surgical services and staff had a clear understanding of what these involved. The division of surgery operational plan 2016/17 outlined the strategy for the surgical specialties.
- There was effective teamwork and visible local leadership within the services. Staff were positive about the culture within the surgical services and there was routine public and staff engagement.

Vision and strategy for this service

- The trust mission statement was; “Our purpose is to be recognised as the centre for acute and specialised hospital services in Lancashire and South Cumbria, providing the highest standards of compassionate, safe care that gives our patients a positive experience, excelling in research, innovation and teaching, developing our staff to reach their potential, and improving the health and wellbeing of our diverse communities.”
- This was underpinned by a set of five values and behaviours; 'caring and compassionate', 'recognising individuality', 'seeking to involve', 'team working' and 'taking personal responsibility'.
- The division of surgery operational plan 2016/17 outlined the strategy for the surgical specialties and listed a number of key targets relating to quality and safety, IT, workforce and capacity and demand. This included recruitment and retention of nursing and medical staff, developing nurse-led clinics and services, improving seven day services and review and improvement of patient pathways and capacity and demand.
- The mission statement, values and objectives had been cascaded to staff across the surgical services and staff had a good understanding of these.

Governance, risk management and quality measurement

- There were monthly divisional and specialty level governance and quality and safety meetings and monthly departmental staff meetings across the surgical services. There was a set agenda for these meetings with standing items, including the review of incidents, key risks, audit findings and monitoring of performance.
- Risks were documented and escalated by the service appropriately. The divisional risk register listed risks relating to surgical services and this showed that key risks had been identified and these were regularly assessed and updated.
- Local specialty-level risk registers were in place but these were not fully embedded across all the surgical specialties. However, we saw that key risks for each surgical specialty services were logged on the divisional risk register, which meant risks were appropriately identified and assessed.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that routine audit and monitoring of key processes took place across the ward and theatre areas

to monitor performance against objectives (e.g. patient safety, staffing and training). This information was cascaded to the ward and theatre managers through performance dashboards.
- The performance dashboards from March 2016 to July 2016 consistently Identified performance shortfalls in areas such as safeguarding training levels, staff appraisals and 18 week referral to treatment (RTT) waiting times that were below the hospital's internal targets.
- This information had been routinely reviewed at departmental and divisional meetings. However, the remedial actions taken so far were not put in place in a timely manner and actions taken so far had not been effective in improving compliance in areas such as training compliance and 18 week RTT compliance.

Leadership of service

- The surgical services were incorporated across two divisions as part of a new divisional structure that had been in place since December 2015. The surgical specialties and ward areas formed part of the surgical division. The theatres formed part of the diagnostics and clinical support division. Each division was led by a divisional director, who was supported by a divisional medical director and a divisional head of nursing.
- The surgical specialities in the surgical division were incorporated into directorates within three clinical business units; oncology / head and neck, surgery and trauma. Each clinical business unit had a clinical business manager. Each surgical specialty had a clinical lead, specialty business manager and matron in place. The surgical wards were led by ward managers that reported to their respective matrons.
- The theatres formed part of theatres and outpatient's clinical business unit within the diagnostics and clinical support division. There was a theatre matron responsible for overseeing the services.
- The new divisional structure had only been in place since December 2015. This meant a number of departmental leads (such as clinical leads, matrons or business managers) were still new in post. Staff across the services told us governance and routine meeting processes that had been incorporated along with the structure change were still being imbedded as a result of personnel changes and new reporting structures.
- The theatres and ward based staff told us they understood their departmental reporting structures clearly and described their line managers as approachable, visible and who provided good support.

Culture within the service

- The staff we spoke with were highly motivated and spoke positively about the care they delivered. Staff told us there was a friendly and open culture. They told us they received regular feedback to aid future learning and that they were supported with their training needs by their managers.
- Records showed the average monthly staff turnover rate across the surgical division ranged between 10.44% and 10.85% between March 2016 and July 2016. This was slightly higher than the hospital's target of 10% turnover.
- During this period, the average monthly staff sickness rate across the surgical division ranged between 4.4% and 5.27%. This was higher than the hospital's target of 4.2% sickness.
- Staff sickness levels were reviewed daily in the wards and theatres and staffing levels were maintained through the use of bank and agency staff as well as the existing staff working additional hours.

Public engagement

- Staff across the surgical services told us they routinely engaged with patients and their relatives to gain feedback from them. This was done informally through daily interactions and formally through participation in the NHS Friends and Family test.
- A number of ad hoc patient feedback surveys were carried out in a small number of surgical specialties. The services also received patient feedback from surveys conducted by external organisations such as Healthwatch.
- Public engagement was also conducted through patient focus groups and ad hoc events. For example, an orthopaedics event was held in March 2016 to provide information about the orthopaedic services delivered by the trust.

Staff engagement

- Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards, theatres, and day case areas.

- The trust also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- The NHS staff survey of 2015 showed the trust had three positive findings out of the 34 indicators with 29 findings within expectations and only two negative findings. They were for 'effective team working' and 'organisation and management interest in and action on health and wellbeing'.
- The findings from the audit had been discussed with staff through focus groups across the surgical specialties and there were action plans in place to improve on the negative findings from the staff survey.

Innovation, improvement and sustainability

- Staff on ward 2b (neurosurgery) trialled a 'collaborative learning in practice' (CLIP) process to support student nurses during their placement. The CLIP aimed to increase placement capacity, enhance student and mentor satisfaction and in turn improve the patient experience.
- Ward staff and student nurses spoke positively about the process and told us it allowed student nurses to receive more training and support during their placement and increased the likelihood of student nurses returning to work in the hospital after qualification.
- Medical staff on the surgical wards developed a 'sticker' that was placed in patient records. This was used as a checklist and included prompts for staff check for completion of processes such as VTE assessment reviews, antibiotic prescribing reviews, fluid balance chart reviews, blood test reviews and patient observation chart reviews.
- The divisional director and the divisional medical director for surgery told us the key risks to the services were around staffing and patient access and flow processes. They were aware of how to address these issues and action plans were in place to improve the services.
- The surgical services were financially challenged along with the remainder of the trust. Records up to July 2016 showed the surgical services were approximately £288,000 in deficit.
- Work was being done to drive quality improvements that would not have a detrimental effect on the trust's financial position. However, there was a risk that improvements could be delayed / deferred as a result of financial pressures. For example, a proposed business case to open a second emergency theatre was submitted in January 2016 and it was not clear if funding for this had been approved at the time of our inspection.

Critical care

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

Information about the service

The Critical Care Unit at Royal Preston Hospital is located in the Medicine Division for management and governance purposes. The Medicine Division is further divided into Acute Medicine, Long-term Conditions and Specialist Medicine. The Critical Care Unit is under the Acute Medicine Business Unit, together with the Emergency Department, Assessment Units, Ambulatory Care and Paediatrics. A Clinical Business Manager, supported by two Speciality Business Managers, manages the Acute Medicine Business Unit. A Divisional Medical Director and a Divisional Director, supported by the Head of Nursing, manage the Medicine Division overall.

The trust had recently restructured the organisational divisions.

The Critical Care Unit has 24 beds. There are fourteen Level 3 beds and 10 Level 2 beds, making up 8760 available critical care bed days per year. From April 2015 to March 2016, the Critical Care Unit accepted around 1300 admissions. Some patients were transferred from the Chorley Hospital site to Preston after their initial admission. During this period, there were 164 deaths in the Critical Care Unit and 1129 discharges.

We inspected the Critical Care Unit between 27 and 30 September 2016 as part of a comprehensive inspection of the trust. During our visit we spoke to four patients; two relatives and 44 staff. These included junior and senior nursing staff, junior and senior doctors and managers at both unit and divisional level. We observed care and treatment, the environment and equipment and examined four care records and prescription charts. We have also reviewed performance data about the Critical Care service.

We also visited two “high observation” or “high dependency” areas within specific speciality wards. These were on Ward 2a (neurosurgery), where there are two 4-bedded bays of Level 2 beds and Ward 23 (Respiratory support); where there are two Level 2 beds in use. There were supposed to be four Level 2 beds on this ward, but two had been downgraded temporarily due to a lack of adequate staffing.

Critical care

Summary of findings

We have previously inspected the hospital in July 2014 and gave critical care services an overall rating of good. Following this inspection we rated critical care services at Royal Preston Hospital overall as requires improvement because:

- Eighty three percent of the beds on the unit were not compliant with the Department of Health Building Note 04-02 for Critical Care Units that specifies the minimum amount of bed space required to safely locate and utilise required equipment.
- Plans to expand and rebuild the unit to meet required bed spaces and provide adequate storage, and staff and visitor facilities had not been undertaken due to financial constraints.
- Flooring in the unit was in a poor condition and presented a tripping hazard and potential infection control risks.
- There was a shortage of pharmacists, dietitians and physiotherapists to meet the needs of patients across seven days a week.
- Mandatory training uptake levels were low for some subjects, including safeguarding children and adults training.
- Appraisal rates were low at 62% and this was a lower rate than at the previous inspection.
- Audits were not always followed up with action plans and a number of action plans had not been update for years in some cases.
- The service was not meeting the Intensive Care Standards guidelines for 50% of nursing staff to have undertaken a post-graduate qualification course in critical care nursing.
- There was limited monitoring of patient satisfaction.
- Seventy one percent of patients admitted to the critical care units experienced a delay in their discharge.
- Bed occupancy was consistently higher than the England average.
- Daily emergency admissions exceeded the anticipated rate for which beds were reserved.

However;

- The critical care services were well-led and staff were aware of the trust's vision and values.
- We found that there were governance frameworks in place and risks were appropriately identified and monitored.
- There was clear leadership throughout the service and staff spoke positively about their leaders.
- Staff were able to report incidents and were knowledgeable about the types of incident they should report.
- We saw evidence that learning from incidents and complaints was routine and this learning was disseminated.
- Infection control was effectively managed and the department was visibly clean. Routine infection control audits were undertaken.
- Nurse and medical staffing was sufficient to meet patients' needs.
- Patients received effective care and treatment that followed national clinical guidelines, was tailored to their individual needs, and was delivered by competent and professional staff.
- The service participated in local and national audits.
- Staff sought appropriate consent from patients before delivering treatment and care.
- Staff were knowledgeable about the Mental Capacity Act and considered this where relevant.
- Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality.
- Patients spoke positively about the way staff treated them.

Critical care

Are critical care services safe?

Requires improvement

At the previous inspection in July 2014 we rated safe as good, following this inspection we have changed this rating to requires improvement because:

- The Critical Care Unit was not compliant with the Department of Health Building Note 04-02 for Critical Care Units regarding the specified minimum amount of bed space required to safely locate and utilise required equipment.
- Plans to expand and rebuild the unit had been changed several times, progress was limited by the financial constraints on the trust and the planning of the long-term future of the hospital buildings overall.
- The unit flooring was in a poor condition and could not be easily fixed.
- There was a potential infection risk as there was no record held of due dates for changes and the curtains were not disposable and dated.
- Storage facilities were inadequate; intravenous (IV) fluids were not stored securely and in accordance with trust policy. There was a risk that some storage areas were accessible to visitors to the department.
- The service was not meeting national guidelines for the number of pharmacists on the unit that recommended and there was no specialist critical care trained pharmacist available on weekends. The shortfall had been removed from the departmental risk register to become part of a trust wide review but the review had not been progressed since then. Following a meeting between the Chief Pharmacist and Critical Care Governance Team, it was moved back to the Critical Care risk register and plans were being discussed around a seven-day service with an action for Pharmacy to review seven day staffing.
- Mandatory training uptake levels were low for some subjects, including life support and safeguarding training.
- Nurse staffing ratios on the two wards where there were high dependency Level 2 beds were not consistently set against the patient acuity.

However:

- Staff were aware of how to report incidents and feedback from incidents was provided and lessons were learned and distributed to facilitate learning.
- There was a low rate of serious incidents in the service and the service had reported no never events.
- Safety performance was monitored and safety thermometer data showed that rates of avoidable harm were within national expectations.
- Staff were aware of how to raise and manage safeguarding issues.
- Infection rates were low and staff observed appropriate measures to protect patients from avoidable infections.
- The environment was suitable for the delivery of patient care and equipment was well maintained.
- Staff managed medicines well and completed patient records correctly.
- Medical staffing and skill mix was sufficient to ensure safe patient care.

Incidents

- All staff had access to the trust wide electronic incident reporting system. Staff were able to demonstrate how they would report an incident or a “near miss” using this system. Staff were aware of the types of incident they should report.
- Staff had access to a flowchart showing the reporting process and duty of candour process and this had been widely disseminated.
- Staff were aware of duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff gave examples of occasions when they had told patients something had not gone as planned and explained how they would exercise the duty of candour.
- Designated band 7 nurses were assigned lead responsibilities for the investigation of specific areas when incidents were reported. For example, all tissue viability (pressure ulcer), staffing or blood sampling related incidents would be investigated by the band 7 designated to those incidents. A root cause analysis was undertaken for all tissue viability related incidents and these were reviewed together with the Head of Nursing.

- Tissue viability related incidents were no longer the highest category of incidents, as they had been at the last inspection and the number of this type of incident was reducing.
- There were safety huddles before the start of a shift, during which wider trust incidents were discussed. Incidents were discussed in Band 6 and 7 meetings with consequential actions.
- There was mapping of incident trends and lessons were learned from these and discussed at team and weekly mortality and morbidity meetings.
- The unit held a weekly mortality and morbidity handover meeting each Wednesday lunchtime.
- We attended a mortality and morbidity handover meeting as part of our inspection. The meeting was attended by five consultants, three junior doctors, nine nurses; the matron; the governance manager; three critical care outreach workers, a medical student and a discharge co-ordinator.
- All deaths that occurred in the Critical Care Units were discussed at this meeting. There was an average of four deaths per week. The consultants used a mortality and morbidity review proforma that was completed for all dying patients and there was a central spreadsheet to collate all results. Each death was discussed at the meeting in detail and scores were given on the assessment of care, multidisciplinary working, the quality of records and documentation and engagement with relatives (such as in relation to organ donation and bereavement services offered). Things that could have been done better were discussed with staff at the earliest opportunity and there was an opportunity for open discussion on how improvements could be made.
- The meeting was in accordance with the Guidelines for the Provision of Intensive Care Services produced by the Faculty of Intensive Care Medicine and the Intensive Care Society
- In the four months from April until July 2016, the Critical Care Unit at the Royal Preston Hospital had reported 264 incidents. Most of these were rated as no, or low harm. Available data showed that in the six months from October 2015 to March 2016, the trust had reported 6097 incidents and 77% of these were classified as causing no harm, 19.4% as low harm, 3% as moderate harm, 0.5% as severe harm and 0.2% as causing death.
- On the Critical Care Unit, the highest category of incidents was nasogastric (NG) feeding tubes being accidentally dislodged or removed by the patient. There were 55 such instances recorded from April to July 2016. There were 33 incidents recorded around medication or fluids prescribing and administration, 31 incidents related to pressure ulcers and 29 related to medical devices, equipment or supplies. We were told that there was an issue with nasal pressure ulcers caused by tubing and they had tried a different method of securing the tubing (the “hammock method”), but this had not reduced the number of instances occurring.
- There had been no “Never Events” (very serious, wholly preventable patient safety incidents that should not occur if preventative measures are in place) reported in the twelve months before our inspection.
- Serious incidents were reported through the Strategic Executive Information System (STEIS).There were no serious incidents reported to STEIS in the 12 months prior to the inspection at the unit.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and ‘harm free’ care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism, or VTE) were monitored on a monthly basis.
- The service were recording and monitoring data in line with this initiative. Information on performance in relation to this initiative was discussed at managerial and staff meetings. We reviewed information for 12 months prior to the inspection and this showed that the service and unit performed within the expected range for falls with harm, catheter urinary tract infections and new pressure ulcers.
- There were Safety Thermometer performance boards displayed in the critical care corridor.
- From July 2015 to July 2016 there were no falls with harm; nine pressure ulcers of grade 2 and above and 3 recorded catheter associated urinary tract infections (C.UTIs) at level 3 (severe) across both units.

Cleanliness, infection control and hygiene

- The unit effectively managed cleanliness, infection control and hygiene. Rates of infections were low and staff followed measures to protect patients from infections.

Critical care

- We saw that the environment in the Critical Care Unit was visibly clean and that staff adhered to good practice for the control and prevention of infection. Staff were bare arm below the elbows in clinical areas and washed their hands after dealing with a patient.
- Staff were using personal protective equipment (PPE), such as gloves and aprons and changed this equipment between patient contacts, in line with trust policy.
- Dated "I Am Clean" stickers were in use in the department to indicate when equipment had been cleaned.
- Equipment trolleys in the department carried a label that stated when they had been cleaned. The equipment was visibly clean.
- Sharps bins were labelled correctly, were not overfilled and were kept closed when not in use.
- There was adequate access to hand washing sinks and hand gels.
- The service undertook a monthly infection control and prevention audit, which was compiled into a quarterly report. This report showed that the service met the 90% standard for three out of four quarters (2015/2016) in relation to isolation, precautions and environmental factors. However, the service failed to meet the 98% compliance standard for correct staff uniform factors. The report also showed that the service met the 100% standards for dealing with central venous catheters in all four quarters.
- The service also undertook quarterly audits in relation to preventing surgical site infections for patients who were admitted to the Critical Care Unit, either pre-, or post-surgery. The audit looked at four key areas, including pre-operative screening and post-operative care. Information provided by the service showed that the service met all four of these standards in 100% of cases audited against a target of 98% in the last three quarters of 2015 and the first quarter of 2016.
- The service audited compliance with the trust and service policy and process for dealing with suspected and diagnosed clostridium difficile infections. A report showed that the service met 100% of standards looked at for last three quarters of 2015 and the first quarter of 2016.
- The unit had reported on Health Care Acquired Infections (HCAI's) quarterly until January 2016. This was a paper audit. There was an expectation that much of the data could have been drawn from the Quadramed Paperlite system, but the second phase of this had been delayed, so data could not be reported. Some of the HCAI's assurances were available through the Intensive Care National Audit and Research (ICNARC) data. Concerns about the lack of data reporting had been raised with the head of Information Technology.
- There were two MRSA (methicillin-resistant staphylococcus aureus) acquisition cases on the unit between July 2015 and July 2016 and four C. Difficile (Clostridium Difficile) cases in the same period. All the cases had been assessed as being unavoidable. There was a "Root Cause Analysis" report for each case.
- Audits were carried out on the safe insertion and maintenance of urinary catheters and vascular access devices, in accordance with NICE guidelines QS61. The urinary catheter audit, carried out in Quarter 1 of 2016, showed 100% compliance for insertion, action and ongoing care against a trust target of 98%. The trust audit on vascular devices, undertaken in July 2016, showed that there was 99% compliance for having an approved document in situ and 98% compliance with documentation being fully completed. This was against a trust target of 98%.
- The curtains around the beds in the unit were not dated and were not disposable curtains. There was no record on the unit of when the curtains were due to be changed.. We were told that staff would call the housekeeping team if the curtains were dirty or soiled and required changing.
- Hand hygiene audit data had not been disaggregated by the trust. Trust wide audit figures for July 2016 showed that overall compliance was 94% against a trust target of 95%. Doctors were seen to be 97% compliant, nurses were 92% compliant and healthcare assistants were 93% compliant. We were told that, in the Critical Care Unit, hand hygiene audits often showed only around 80% compliance. Staff were good at washing hands between seeing patients, but not when first entering the unit.
- The environment in the critical care unit was not conducive to isolating patients due to the lack of space. There were five side rooms; however, in areas 1 and 3 of the unit, should this be necessary.

Environment and equipment

- In terms of the environment, the Critical Care Unit was not compliant with the Department of Health published "Health Building Note 04-02" (HBN 04-02) for Critical Care Units. This guidance determines the equipment

that needs to be located in a critical care unit and the minimum amount of space required per bed to safely locate and utilise that equipment. The guidance states that each bed space should be a minimum of 25.5m2. Twenty of the bed spaces were only in the region of 18m2.

- The long-term solution to address the issue was to design an expanded unit with adequate space for the number of beds required. In the shorter term, risk assessments had been carried out and control measures were put in place to minimise the risk to patients because of the reduced bed space. Control measures included keeping the floor space around the beds as clear as possible, infection control monitoring and use of aseptic non-touch technique.
- The issue with bed spaces had been on the Risk register since 2013. Only the four beds in Area 5 met the requirement. However, these beds were located across the corridor from the main critical care unit, next to a surgery recovery bay. They could not accept Level 3 patients (patients receiving advanced respiratory support or a minimum of two organs supported) because it was deemed that they were too far from the main unit for doctors to get to the beds quickly. If patients in this area were escalated to a Level 3 they were moved into the main unit.
- At the time of our inspection, one area of the unit, Area 4, was closed to patients. This was slightly detached from the main unit and had been closed due to a lack of nursing staff. There were plans in place to reopen the four beds in this area in November 2016 when more nurses had been recruited.
- Since 2014, four expansion projects for the critical care unit had been devised. These had included a plan to build 28 new beds adjacent to the existing unit, followed by a refurbishment of the existing unit to make 42 beds in total. Another expansion plan was to build a new building to house a 48-bedded unit that would be future proof with around 85% capacity in excess of 10 years. This design was curtailed to 40 beds because of costs and then the project was suspended following the involvement with Monitor with the trust in July 2015. Monitor is now part of NHS Improvement and because of financial challenges had stepped in to monitor and make decisions on any proposed investments by the trust.
- At the time of inspection, there was a new expansion project being discussed that involved a 14-bed expansion on and around, the footprint of ward 1 that was next to the existing unit with a refurbishment of the current unit. This would bring the bed total to 34 beds that would meet requirements on safe bed spaces. An outcome on funding for the expansion works was awaited.
- The flooring in the unit was in a very poor condition, being cracked and held together with tape. The floor was very uneven and there were visible humps in places. The condition of the floor was on the risk register, but we were told that the whole floor would have to be dug up and there would have to be a major decant to permanently fix it.
- Storage facilities in the unit were inadequate. Although tidy and well organised, every available spare space was being used for equipment storage. This included corridors and adjacent clinical areas. There was not enough room to have one storage unit in the department. The unit was interviewing for a housekeeper to take charge of ordering stocks and organising the stores.
- Some storage areas were accessible to visitors to the unit although there were appropriate notices on cupboard doors to advise that the area was for staff only.
- However, we saw that each patient bed area had an equipment trolley containing all the equipment required to treat the patient, including in an emergency situation.
- Equipment checks, cleaning and maintenance was appropriate. Resuscitation trolleys were stock-checked daily by the night shift staff and safety checklists were completed daily.
- The unit used a “six point of identification” syringe labelling system that arose from a Coroner’s report. This ensured that the ends of tubing were correctly labelled, indicating what the tubes were for and connected to so that the right ends could be unplugged safely.
- Equipment conforming to relevant safety standards was regularly serviced and maintained by two - technicians, who were attached to the unit. The technicians also assisted on future departmental planning and training staff on equipment use.
- The technicians were supported by a Medical Engineering Department that were ISO 9001:2008 accredited for the management, maintenance and repair of medical devices.

- The trust policy for the management of medical devices was in date and published on the intranet..

Medicines

- Medicines were stored correctly in locked cupboards and fridges and maximum and minimum fridge temperatures were checked and recorded daily in accordance with national guidance. There were appropriate arrangements in place for the destruction of unwanted and expired medicines.
- Checks of the stocks of controlled drugs were conducted every night. Entries in the Controlled Drugs book were found to be in order.
- Nursing staff were aware of the policies on the administration of controlled drugs.
- However, we noted that IV fluids in the unit were not stored securely. They were kept separately in a store room, but the room had an unlocked door. This was contrary to the trust's Medicines Storage Policy and there was a risk that the room was accessible to members of the public on the unit. We raised this issue during the inspection and it was proposed that a door entry key card system would be installed to secure the room.
- There was one permanent critical care specialist pharmacist in post, supported by 0.3 WTE pharmacy staff from other areas. The Guidelines for the Provision of Intensive Care Services (GPICS) recommends that there should be 1.9 WTE pharmacists available for 24 beds.
- A trained critical care pharmacist delivered prescribing services on weekdays. On-call non-specialist pharmacists delivered weekend services, although they had access to specialist advice if needed.
- The specialist pharmacist did not routinely attend the ward round, but did attend all patients on the unit and communicated verbally and via the Quadramed electronic patient record system with consultants. The specialist pharmacist was available during the ward round if required.
- An audit of GPICS compliance indicated that the shortfall in pharmacists had been on the Departmental Risk register, but had been removed to become part of a trust wide review, however, this review had not progressed since then. Following a meeting between the Chief Pharmacist and Critical Care Governance Team, it was moved back to the Critical Care risk register and plans were being discussed around a seven-day service with an action for Pharmacy to review seven day staffing.
- Pharmacy deliveries to the critical care unit took place three times per week.
- There was a prescribing guide in place and this included guidance on auditing and recording all pharmacist interventions. The threshold for recording interventions had been lowered, so that there was an average of 200-250 per month in 2016, compared to 60-100 per month in 2014 when the reporting threshold was lower. Interventions were recorded for four main reasons: to ensure patient safety and improve quality and continuity of patient care; to provide evidence to demonstrate the additional value of pharmacist input; to have an accurate record available for scrutiny where decisions could be challenged and for monitoring incidents or near misses in relation to prescribing, dispensing or the administration of medicines. The intent was to discuss feedback monthly at the mortality and morbidity meetings to reduce prescribing and administration errors.
- The use of an electronic end-to-end E-prescribing and medicines administration system was in development, with a view to reducing prescribing and administration errors. Introduction of the system would follow the department re-fit and expansion.
- We reviewed four patient prescription cards on the unit. All were signed and dated, allergies had been documented and, where applicable and antibiotics had been prescribed as per guidelines. Administration of venous thromboembolism (VTE) prevention medication was documented and the writing was legible in all records.

Records

- Since our last inspection, the critical care unit had fully moved to an electronic patient record system. This meant that all records were traceable and available.
- Appropriate risk assessments and prompts to specific care bundles were included in the system.
- We were satisfied that the patients' individual care records kept people safe.
- Treatment plans were documented on the system and visible to all relevant staff. Patient and relative conversations were documented. Patients were consulted on the ward round where possible.

- We examined four sets of patient care records. All showed how the patient had been admitted to critical care, whether this was pre-booked for post-operative care or following a patient review and escalation. All the records indicated that a VTE risk assessment had been conducted; there had been a daily consultant-led ward round; fluids had been assessed, fluid lines had been checked, a review of sedation and antibiotics had taken place and there had been assessments of pressure areas and of the nutritional status of the patient. Two of the records also evidenced input from the multidisciplinary team.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and confident about making referrals to protect adults and children from suspected abuse.
- The trust had safeguarding policies and procedures in place, which were readily available on the trust's intranet site.
- Safeguarding was part of the mandatory training programme for all staff. Staff on the unit at Band 6 or above had undertaken Level 3 Adult Safeguarding and staff below Band 6 were trained at Level 2.
- The trust nominated lead for safeguarding was the Associate Director for Patient Safety and Governance. There was a lead practitioner for adults and a named lead nurse for children. The rest of the safeguarding team comprised 2.6 whole time equivalent (WTE) band 6 staff and 1.6 WTE Band 3 Administrative Officer.
- The trust had representation on the subgroups of the Lancashire Adult Safeguarding Board and had established its own Safeguarding Board with a non-executive director as a member.
- All staff had to attend a child safeguarding training session though there were no spaces on the courses at the time of our inspection for staff to be able to attend. The trust was intending to roll out an e-learning package for staff in addition to the sessions, although this had not happened when we inspected.
- At the time of our inspection, 64% of all Critical Care staff requiring level two safeguarding vulnerable adults training had undertaken the course. This was lower than the trust target of 75%. However, 87% of all Critical Care staff requiring level three safeguarding vulnerable adults training had undertaken the course and this was higher than the trust target of 75%.
- Data showed that no Critical Care staff required level three safeguarding children training. The number of staff requiring level two safeguarding children training was 236. However only 15 staff (6%) had undertaken this training. This was below the trust target of 90%. We saw that 96% of Critical Care staff requiring level one safeguarding children had undertaken the course and this was above the trust target.
- All staff had to undertake an e-learning package on child sexual exploitation and we were told by the Matron that there was an increased awareness of female genital mutilation (FGM) amongst staff.
- Safeguarding concerns on the unit were discussed at the weekly mortality and morbidity meeting. . We were given examples of safeguarding concerns that had been raised by staff about two patients during the week of our inspection.

Mandatory training

- There were electronic records of compliance with mandatory training for staff. Mandatory training compliance was reviewed regularly by the service lead and matron.
- Across the Medicine Division, uptake levels for mandatory training subjects were variable between subjects with some areas of high uptake, which met the trusts target and some areas of low uptake, which did not meet the trusts target.
- Training was delivered via a mixture of e-learning and face-to-face training. Training courses required to be undertaken by staff included an annual fire safety course, moving and handling, information governance, equality and diversity and counter fraud, bribery and corruption.
- Staff were required to complete further courses, which included adult and child safeguarding, infection control, health and safety and record keeping.
- All nursing staff responsible for the administration of intravenous medications were required to undertake mandatory training in this subject. Records showed that 100% of staff had undertaken this training at the time of the inspection.
- The trust required that all staff involved with moving and handling patients undertook training in this subject. Records showed that 24% of nursing staff had undertaken this training against a target of 60%.

- Nursing staff were required to undertake mandatory training in aseptic no touch technique (ANTT), which was used to prepare infusions. The trust target for this training was 85% and 53% of nursing staff within the unit had undertaken this training.
- The trust required that minimally 85% of staff undertook basic life support with training on how to use an automated external defibrillator. Records showed that only 17% of nursing staff and 40% of medical staff had up to date training in this subject. Some staff were also required to undertake a higher level of life support training (Advanced Life Support Training); the target for this training was 90%. Records showed that only 79% of nursing staff had undertaken up to date training in this subject.
- The critical care units had three nurse educators, who were employed in educational roles and were able to deliver training to nursing and associated staff on the unit and to offer additional clinical support on the unit. This was an increase in these roles since our last inspection and meant that recommended nurse educator ratios to number of nurses had been achieved in accordance with the GPICS standards.
- At the time of our inspection, 89% of nursing staff in Critical Care were up to date with mandatory training against a trust target of 90%.
- Staff told us they were encouraged to attend mandatory training and their manager reminded them when their mandatory training was due for renewal.

Assessing and responding to patient risk

- The weekly mortality and morbidity handover meeting discussed all patients who had been on the Critical Care Unit for more than 14 days. These were considered to be complex patients at higher risk. Each patient's case was discussed in detail, with a view to escalating care and treatment where required, or moving the patient closer to a discharge date where there was evidence that the risk of the patient deteriorating was reducing.
- The unit had mapped the incident trend of nasogastric tubes being removed or dislodged by patients and were actively seeking solutions to this. They were working with the surgery theatres on the possibility of using sutures to secure the tubes in place.
- There was a trust National Early Warning Scores (NEWS) system in place for the early detection and escalation of the deteriorating patient.
- There was a clear escalation policy on the same sheet as the NEWS documentation. This linked clinical responses to the scores applied to physiological parameters.
- The trust carried out early warning score clinical audits to ascertain compliance and correct use of the National Early Warning Scores. In an audit in May 2016, wards and departments were visited and data collected on up to 10 patients triggering NEWS. Patient notes and vital chart signs were reviewed to gather evidence of compliance with the five elements of the audit. The Critical Care Outreach Team Practitioner made a judgment on whether the patient had been escalated appropriately according to the timely recognition and response policy. Each ward received feedback on the day of the audit and each ward manager received a hard copy of the audit proforma for his or her timely action.
- The audit was not undertaken on patients in Royal Preston Hospital Critical Care Unit but showed that, across other wards in the hospital, in only 54% of cases, where the NEWS score was greater than five, and the patient may need to be escalated to the critical care unit, that the escalation policy was followed appropriately.
- The critical care outreach team provided cover for the wards and theatre recovery areas across the hospital over seven days between 8am and 8pm. The team expanded in August 2015 and now included a sepsis nurse and an Acute Kidney Injury Service.
- Cover from 8pm to 8am was provided by the Hospital at Night Team. A nurse consultant was responsible for this team in the short term, while a review by a trust working group of the out of hours cover for patients was ongoing.
- Staff were required to carry out risk assessments to identify patients at risk of specific harm, such as pressure ulcers and risk of falls. If staff identified patients susceptible to these risks, staff were required to place patients on the relevant care pathway and treatment plans. We found that patients were placed on the pathway which related to the risks identified including pressure care.
- Staff carried out 'safety huddle' meetings once a day, where specific patient needs were discussed.

Nursing staffing

Critical care

- Acuity (the severity of illness in patients)and skill mix was determined by the Core Standards for Intensive Care Services (2013). There was evidence that managers planned staffing while taking into account the skill mix and competencies of the staff on duty.
- The critical care unit had appropriate and safe nursing staff numbers, compliant with national guidelines on care-compliant staffing ratios. Level 3 patients were cared for on a nurse to patient ratio of 1:1 and Level 2 patients were nursed on a nurse to patient ratio of 1:2.
- A Band 6 Nurse in each bay supported the band 5 Nurses.
- In accordance with the guidelines, there was a Band 8A Matron post, the identified lead nurse who was solely responsible for the critical care unit.
- There was a supernumerary Band 7 Co-ordinator on shift for 24 hours a day, seven days a week. This was compliant with the guidelines.
- The trust had noted a recommendation in the guidelines for additional supernumerary nurses in units with greater than 10 beds. They had received recent permission to add an additional Band 5 nurse per shift to assist in the geographically isolated Area 5. In addition, a briefing paper had been submitted to request an additional two supernumerary Band 6 nurses per shift. At the time of inspection, this paper was awaiting executive review.
- There were three clinical nurse educators in post, one Band 7 and two band 6's. They were responsible for coordinating the education, training and CPD framework for critical care nursing staff and pre-registration student allocation. The guidelines recommended one educator for every 75 staff. The headcount at the time of our inspection was 224 staff.
- The unit was compliant with allocating a period of supernumerary practice to all nursing staff appointed. Those staff who had previous ward experience were allocated a 4-6 weeks supernumerary period, dependent on experience. The unit had recently appointed four newly qualified nurses, who were receiving a three-month supernumerary experience.
- There were very low rates of bank nurse utilisation. There had been some usage during a temporary surge in April 2016 when the Area 4, four-bedded bay was utilised. Staff undertaking bank shifts were critical care unit employees.
- There were no vacancies for Band 7, Band 6 or Band 4 nurses in the unit at the time of our inspection. The unit had just shortlisted 25 nurses to fill seven Band 5 Nurse positions. This would enable them to re-open the Area 4 Bay on weekdays, so that all 28 beds in the unit could be utilised. Area 4 would be able to accommodate Level 2 patients only, because it was a slight distance from the main unit.
- The June 2016 turnover rate for nursing staff within the service was 9.12%. This means that in one year 9.12% of the nursing employees left and were replaced by a new employee. A lower turnover rate indicates stability in the workforce and means that key skills and experience remain within a department. The rate was below the trust target of 10%.
- The sickness rate was 9.5% for nursing staff working in the department, which was higher than the national average of approximately 4%.
- During our inspection, we visited two wards where there were high dependency Level 2 beds.
- We visited Ward 2A – Neurosurgery, where there were supposed to be two four-bedded Level 2 bays. We spoke to the staff nurse in charge of the ward on the day of our inspection. They told us that there were only four nurses on duty and one healthcare assistant for the whole ward (which had around twenty beds). The staff nurse was also supporting a newly qualified nurse on the ward.
- Staff told us that there was never a ratio of one nurse to two Level 2 patients on the ward and that it was only when they reached the point that they were out of their comfort zone that an issue would be raised if they could not cope with the acuity of patients. Staff told us that they did not think that the staffing levels were safe all of the time. The staff nurse did not have records of which patients were Level 2 and told us: "you just know the ones that you have to keep an eye on". They estimated that there might have been three or four Level 2 patients on the ward at that time.
- We also visited ward 23 Respiratory Ward (Bay 7), where there were four Level 2 beds. Two of the beds had been closed temporarily to Level 2 patients due to not being able to staff them on a 1:2 nurse to patient ratio. At the time of our inspection there were two Level 2 patients with tracheostomy on the ward who had been there overnight and there was a further patient who required closer observations. The beds were staffed appropriately for these patients and we were assured that there would be a minimum of one nurse and one health care assistant in bay 7 at all times when there were two Level 2 patients. The unit accepted patients

from the critical care unit, who still required a high level of care. The patients with tracheostomies were overseen by a consultant physiotherapist from the Ventilation Team, who was airways trained and was responsible for weaning patients from tracheostomies. A Consultant from the Critical Care Unit oversaw patients in their absence.

Medical staffing

- During our inspection, we found the critical care services had a sufficient number of medical staff with an appropriate skill mix to ensure that patients received the right level of care. The medical staff also rotated through the unit at Chorley District Hospital.
- The Intensive Care Standards state that there must be a designated Clinical Director and/or a Lead Consultant for Intensive Care. The department previously had a Lead Consultant and an Assistant Clinical Director. However, since moving from part of the Anaesthesia Directorate to part of the Acute Medicine Division, critical care now had its own Clinical Director.
- There were 16 Critical Care Consultants working on the units. Critical Care Consultants were accessible 24 hours a day, 7 days a week. All were members of the Faculty of Intensive Care Medicine and Fellows of the Faculty of Intensive Care Medicine or Fellows of the Royal College of Anaesthetists (or both).
- Consultants covered a number of specialities within the critical care arena and were called upon for advice and training in their own specialities. Examples of areas of expertise among the consultants were critical care anaesthesia, pain management, intensive care unit medicine, delirium and sedation, resuscitation, acute kidney injury, neuro intensive care, sepsis, cardiopulmonary exercise, liver failure, organ donation and end of life care.
- When patients were present in the unit, the staffing levels of consultants to patient ratio did not exceed 1:8 during weekdays and 1:15 during out-of-hours service in line with ICS standards. In general, the daytime consultant to patient ratio was 1:12 with a 1:4 resident doctor to patient ratio. There was a 1:6 resident doctor to patient ratio on weekend days and this increased to 1:12 ratio on nights, with a consultant typically on site until midnight to support. After midnight, a consultant was available on-call within 30 minutes. There were often two consultants available overnight at the Preston unit if the on-call consultant at Chorley was not required there.
- Since our last inspection, there had been an increase in the number of junior doctors on duty from five to six on weekdays, from three to four on weekends and from two to three on night shifts.
- The department had recently recruited a first Advanced Critical Care Practitioner (ACCP) and there were plans to recruit more.
- From August 2016, there had been an improvement to consultant work patterns to deliver continuity of care. They had moved to a block-working pattern that involved three major changes of team per week where previously there had been six. Consultants now worked Monday to Wednesday, Wednesday to Friday or Friday to Sunday, with a three-hour handover and grand round on Wednesday lunchtime. Consultants told us that they preferred block working and patients were receiving better continuity of care.
- Locum doctors were used to cover existing vacancies and for staff during leave. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures.
- The unit was also participating in the Royal College of Anaesthetists Medical Training Initiative that allows a limited number of doctors from overseas to benefit from the opportunities of working in the NHS for a limited period, and receive specialised training, before returning home.
- We saw that daily medical handovers took place during shift changes and these included discussions about specific patient needs. Medical staff across the different grades participated in the medical handovers.

Major incident awareness and training

- The trust had a Major Incident plan that was available on the trust intranet.
- With regard to Critical Care, in the event of a major incident, lower risk patients would be moved within the hospital to other available and appropriate wards to free up beds in the critical care unit.
- The unit had been working with the Surgery Division and another trust to plan what would happen in the

event of a major terrorist attack and in the event of multiple burns victims. Stocks of double-flow oxygen meters were in place in the event of any sort of terrorist attack.

- The trust had also made plans in the event that there was a disease epidemic and the unit had to take in paediatric patients; there was a paediatric escalation plan in place should this happen.

Are critical care services effective?

Requires improvement

At the previous inspection in July 2014, we rated effective as good. We have changed this rating to requires improvement following this inspection because:

- The service provided a report on the audit of compliance against recommendations in relation to critical care outreach services. In 23 of the 67 the standards audited, the service had either no action planned or plan in place or action was planned but not implemented.
- Appraisal rates were low at 62%, which was less than at the previous inspection.
- The service was not meeting the Intensive Care Standards, which state that at least 50% of nursing staff should complete a post qualification in critical care.
- There was no patient toilet on the unit and the patient shower room was used to store commodes.
- The junior doctor's room was very cramped and was not conducive to them being able to carry out their paperwork in a timely fashion.
- There were less dietitians on the unit than recommended in national guidelines and speech and language therapist (SLT) assessments were not taking place in a timely way when being weaned from ventilation.

However;

- Patients accessing critical care services received effective care and treatment that followed national clinical guidelines including those from the National Institute for Health and Care Excellence (NICE) and Intensive Care Society (ICS).
- Patient outcomes were better or similar to the national average for units of a similar size and nature.
- The service participated in local and national audits.
- Patients' nutritional and hydration needs were identified and addressed appropriately.
- Patients received timely analgesia when they required it.
- Patients received care and treatment from competent staff who worked well as part of a multidisciplinary team.
- Staff sought appropriate consent from patients before delivering treatment and care.

Evidence-based care and treatment

- Staff followed policies and procedures based on national guidelines, such as the Intensive Care Society (ICS), National Institute for Health and Care Excellence (NICE) and National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations.
- Policies and procedures reflected current national guidelines and were easily accessible electronically and also in paper form in the department.
- We observed that patients were placed on evidence based care pathways when appropriate.
- The service used the NICE clinical guideline 83 on the rehabilitation after critical illness in adults. The trust audited against aspects of this guideline, however these audits focused on areas outside of the critical care service. The service had an action plan to improve compliance with this clinical guideline, but this action plan had not been updated since 2010 and there was no evidence that any of the actions listed had been carried out.
- The critical care services participated in local and national quality audits and the service had a comprehensive audit plan. This plan included speciality audits, including the use and utilisation of the critical care outreach team and the use of intravenous fluids in critically unwell patients.
- The service was part of the critical network of England, Wales and Northern Ireland. As a part of this network, the service audited key areas of the service and units against standards set out by the Faculty of Intensive Care Medicine (FICM). A gap analysis, undertaken in October 2015, showed that 16 out of 106 standards were partially met by the service; an example of this was that endoscopy for urgent gastrointestinal bleeds was not available for 24 hours a day. There was an action assigned to this issue, which was to develop a 24 hour rota for staff to respond to urgent gastrointestinal

bleeds. However, this action had not been updated since October 2015 and there was no evidence that the issue had been resolved. However, 90 out of the 106 had been fully met by October 2015.

- The service provided a report on the audit of compliance against recommendations in relation out critical care outreach services. In 14 out of 67 of the standards audited, the service was categorised as red, which the trust defined as no action planned or plan in place. In 9 out of 67 of these standards the service was categorised as amber, which the trust defined as action planned but not implemented and in 44 out of 67 standards the service was categorised as green, which the trust defined as recommendation fully implemented. This report did not contain a date of specified location and we were unable to identify any evidence to support that action had been taken in response to the areas highlighted as requiring action.

Pain relief

- Individual care plans included pain management assessments for all patients. This included observing for the signs and symptoms of pain. Staff used a pain-scoring tool and referrals were made to the trust pain team as required.
- We observed that pain relief was routinely prescribed as part of sedation management.
- Pain relief was available on request to patients who were conscious and able to ask for further pain relief.
- In all records we reviewed, which indicated that patients required analgesia, there was an appropriate prescription.
- The critical care staff had guidance available about the medicines used for analgesia.

Facilities

- There was no patient toilet on the unit for those patients who were able to get out of bed and use the facilities. Commodes were available.
- The patient shower room was being used to store the commodes, which made it inaccessible to patients who might be able to use it.
- The junior doctors' office was not large enough to be conducive to them being able to carry out their paperwork in a timely fashion. At the time of our inspection, we saw that the office was cramped, doctors were sharing desks and computers and there were not enough chairs in the room to accommodate the staff using it.
- The visitors' room was very cramped for the number of relatives who were waiting to see relatives or who needed a break. There were not enough seats to accommodate all the visitors to the unit.

Nutrition and hydration

- Staff identified patients who had difficulties with eating and drinking using a nutritional risk assessment tool. Assistance was provided, as they required. Fluid balances were checked, monitored, and noted on patient records during the daily ward rounds.
- We found evidence in patient records that malnutrition risk assessments were completed appropriately in cases where patients were at risk of malnourishment.
- Guidelines for the Provision of Intensive Care Services (GPICS) recommend that there should be 1.2 to 2.4 WTE dietitians for the size of the unit. There was only one WTE dietitian designated to the unit, but this was an improvement since August 2016 as they had previously been shared with other areas.
- The dietitian was involved in the assessment, implementation and management of appropriate nutrition support. They did not routinely attend ward rounds though were available during the round if required.
- All patients with a tracheostomy should have communication and swallowing needs assessed when the decision to wean from the ventilator is made and the sedation hold has started. There were difficulties in getting a speech and language therapy (SALT) assessment in a timely manner and this was often taking more than 24 hours

Patient outcomes

- Intensive Care National Audit and Research Centre (ICNARC) audit data showed the intensive care unit was within the expected range for the ICNARC (2013) and APACHE II (2013) mortality ratio for all patients when compared with similar units nationally. APACHE II is a scoring system designed to make mortality prediction scores based on the severity of disease in patients

admitted to the critical care unit. The unit was within the expected mortality ratio of 1.0 between April 2014 and March 2015, which meant the actual deaths on the unit were similar to or less than the anticipated number.
- The ICNARC data for low risk patients showed that the risk adjusted mortality ratio was within the expected range for the above period.
- The ICNARC data showed the Critical Care Unit performed better than other similar units for out-of-hours discharges.
- Delayed discharges greater than four hours were worse than the England average, but were within expected levels for mean length of stay.
- Unplanned readmission to the critical care unit, within 48 hours of discharge was 0.6%, which was lower than the national average of 1.4% for similar units.
- Delirium/ acute confusion was routinely assessed by nursing staff, in accordance with Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) guidelines. If there were doubts, staff would involve a psychologist to assess the patient.

Competent staff

- Records showed that 81 out 179 of nursing staff across the critical care service, which equated to 45% of staff had completed the post registration award in critical care nursing, which was lower than the Intensive Care Society (ICS) standard for at least 50% of staff to have completed this training. However, a training plan was in place with a projected trajectory to meet this target by September 2017.
- Fifteen members of the nursing staff were to undertake the relevant course, starting in September 2016, and this would take the numbers up to the required 50%.
- Newly appointed staff were required to undertake an induction and their competency was assessed against practice based competencies prior to working unsupervised.
- The Medical Director was the responsible officer for medical workforce re-validation and appraisals. The medical director was supported in this work by a deputy. The trust had a system for appraisals, training and revalidation. Staff were able to upload Continuous Professional Development and 3600 feedback documents. The datix incident reporting system fed into the appraisal and training system to highlight where more training may be required, for example, where staff were involved in repeated incidents or complaints.
- Staff told us they routinely received supervision and annual appraisals. Records showed the annual appraisal completion rate was 100% for medical staff and 62% for nursing staff in critical care against a trust target of 90%.
- Agency and bank staff received a local department induction on arrival to their shifts.
- The nursing and medical staff told us clinical supervision was available and were positive about on-the-job learning and development opportunities. Staff told us they were well-supported by their line managers.

Multidisciplinary working

- We saw evidence that there was effective communication and collaboration between multidisciplinary team members within the service and other specialities.
- Staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks.
- Nursing staff told us they had good relationships with consultants and doctors of different disciplines.
- There was a twice daily Consultant Intensivist led ward round, 365 days per year. There was direct nursing input to the ward round that was attended by the Band 6 leaders from each bed bay and the nurse. Pharmacists and physiotherapists did not usually attend the ward round directly, but were available for input if required. At the consultant shift change on a Wednesday lunchtime, there was a three hour handover and a grand round (where the medical problems of all patients were presented to the clinicians involved in the shift change)
- There was also a twice weekly microbiology ward round and rapid access to telephone advice outside of this. Microbiological input to critical care is essential to the management of the septic patient.
- Safety huddles took place at the start of each shift, during which specific patient needs were discussed and any incidents that had taken place.

Seven-day services

- The unit was open 24 hours a day, seven days a week.
- Staffing rotas showed that nurse staffing levels were sufficient to meet both the trust's and national guidelines during out of hours periods.

Critical care

- There was consultant presence on the ward for 16 hours a day until midnight. From midnight until 8am, an on-call consultant was available within 30 minutes, seven days a week.
- Microbiology, radiological imaging (including CT scanning), physiotherapy and pharmacy support was available outside of normal working hours and at weekends. Physiotherapy support was available on the unit during the day on Saturdays and Sundays.
- Pharmacist services were delivered on weekdays by a trained critical care unit pharmacist. On-call non-specialist pharmacists delivered weekend services, although they had access to specialist advice if needed.
- The lack of a specialist critical care trained pharmacist on weekends had been re-added to the risk register by the Chief Pharmacist, but given a low risk rating. The Critical Care Governance Team had questioned the assessment and requested a meeting to review it. This had taken place just before our inspection. The risk rating was agreed at that meeting and reflected the level of harm and frequency of harm events from medication incidents captured in Datix reports.
- We were informed that emergency endoscopy was available at RPH seven days a week.

Access to information

- The information needed for staff to deliver effective care and treatment was readily available in a timely and accessible way.
- The records we reviewed were easy to locate and easy to follow. This meant staff could access all the information needed about patients easily.
- Information provided in handovers of patients from the unit to ward areas was accurate and detailed, which ensured the receiving staff had all the relevant information they needed.
- Staff were able to access trust policies and processes easily by using the trusts internal intranet pages.

Consent and Mental Capacity Act

- Staff sought consent, from patients who were conscious and able to give consent, prior to undertaking any treatment or procedures and documented this clearly in patient records.
- Staff had the appropriate skills and knowledge to seek consent from patients.
- Staff were able to articulate how they sought informed verbal and written consent before providing care or treatment.
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative) that could legally make decisions on the patient's behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals in "best interest meetings" at which all options were discussed, before agreeing the best course of action.
- Staff had a good understanding of the legal requirements of the Mental Capacity Act 2005.
- Staff had awareness of what practices could be deemed as restraint and displayed an understanding of the deprivation of liberty safeguards (DoLS) and their application.
- In response to cases where patients, who lacked capacity, were discharged to a ward and became agitated or suffered from delirium, staff routinely completed DoLS paperwork on discharge as security staff requested this.
- Staff were supported on the Mental Capacity Act and Deprivation of Liberty Safeguards by the Adult Safeguarding lead.

Are critical care services caring?

Good

At the previous inspection in July 2014 we rated caring as good, we have maintained this rating following this inspection because:

- Staff treated patients with kindness, dignity and respect.
- Staff provided care to patients while maintaining their privacy, dignity and confidentiality.
- Patients spoke positively about the way staff treated them.
- Patients told us they were involved in decisions about their care and were informed about their plans of care.
- Staff took their time to support patients and ensure they knew what was happening.

- Staff showed that they understood the importance of providing emotional support for patients and their families.
- There was follow-up care for patients who had been on the unit for longer than four days and this included psychological support.
- There were bereavement services available for patients' relatives, including chaplaincy and staff were aware of how to access these.

However:

- There was limited monitoring of patient satisfaction and the service did not participate in the NHS friends and family test.

Compassionate care

- The service did not participate in the NHS friends and family test (FFT). They undertook their own local satisfaction surveys.
- We observed staff treating patients who were present on the unit with kindness and compassion during all interactions. Staff took time to interact with patients and treated them with dignity and respect.
- We spoke with four patients, who gave us positive feedback about how staff treated and interacted with them.
- One post-operative patient told us that they could not fault the care they had received from the nurses who were especially friendly and they told us that the food they had received was lovely.
- Two further patients told us that the care could not be faulted and one made the point that they had been well-informed about what had happened to them. Even though their injuries were serious, they felt that they were given the full facts in a compassionate way.
- Relatives told us that they were very happy with the care given to the patients, but that there was a lack of private rooms available where staff could speak with patients' relatives privately in order to maintain confidentiality. We saw one room that was used for meetings with relatives, but we were told that this was insufficient as it was also often used as an overspill room from the allocated relatives' waiting room.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care and communicated with patients in a way that they could understand.
- Patients and their families told us that staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them verbally and felt fully informed about their care and treatment plan.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions.
- Families were encouraged to keep patient diaries and we were told that many families took this up. This enabled patients to see and process their stay in the unit when they had recovered. The unit had a leaflet about what steps the patient may have gone through before discharge.
- The unit were looking into the legalities of keeping photos of patients throughout their treatment so that patients who later wanted to know and understand what had happened to them whilst on the unit could be shown more visually.
- Those patients that had been on the unit for four days or more were invited to a follow-up clinic. Clinics were held every week, seeing four or five patients per clinic. The patients met with a Band 6 nurse from the Discharge Team and a psychologist where any potential psychological or physical problems they may be experiencing post-discharge were discussed with referrals for further help and treatment where necessary. The patients were also brought back to the unit, shown their bed and staff talked through what had happened to them whilst they were there.

Emotional support

- Staff understood the importance of providing patients and their families with emotional support.
- We observed staff providing reassurance and comfort to patients and their relatives.
- Patients told us that staff supported them with their emotional needs.
- Chaplaincy services were available on site to provide additional emotional support and staff were able to tell us how they would access these for patients.

Critical care

- The service had developed a support group for patients and their families following discharge form the unit. This group allowed patients and their relatives to share their experiences and gain support from others.
- Staff could also seek support from a palliative care team if a patient required end of life care. Patient and relative handbooks provided information about bereavement, counselling, chaplaincy and spiritual support services were available.
- There was a bereavement service in place to support patients, relatives or staff.
- Once a year, the critical care service held a remembrance service for relatives of patients who had died on the units. A local supermarket donated flowers for the service.

Are critical care services responsive?

Requires improvement

At the previous inspection in July 2014 we rated responsive as requires improvement, this was because elective surgery cases were cancelled due to critical care bed availability; the theatre recovery area was used as a place to care for patients. Bed occupancy was generally over 90%; the critical care outreach team was unable to provide a 24/7 service and there was only on-call pharmacy service at weekends. We have maintained this rating following this inspection because:

- There was limited service planning for critical care as long-term plans for the unit had not been secured due to a lack of funding and the inability of other services to move.
- Facilities did not meet the needs of patients' relatives; visiting rooms were too small to accommodate visitors comfortably.
- There was insufficient physiotherapy staffing to meet the minimum expected standards.
- Seventy one percent of patients admitted to the critical care units experienced a delay in their discharge.
- Delayed discharges of greater than 8 hours were higher than the national average.
- Bed occupancy had risen to higher than the England average of 85% and had remained consistently so since April 2016.
- Daily emergency admissions exceeded the anticipated rate for which beds were reserved.

However;

- There was sufficient capacity within the critical care service, which meant patients were admitted promptly and received the right level of care.
- Patients' individual needs were considered and accommodated.
- Complaints were well managed and there was a trust wide approach to investigation of these complaints.
- The trust had an escalation plan in place and staff followed the steps set out in this policy in times of increased pressure.

Service planning and delivery to meet the needs of local people

- The critical care services were provided for adults over the age of 16 years.
- The service had experienced problems in service planning in recent years, having drawn up four plans for the future of the unit that had not been delivered. The plans ranged between a complete rebuild of the unit in another location on the site to the latest plan that involved an expansion of the unit into the ward next door.
- The latest plan was viewed upon as providing a unit that would get them through the next ten years with 85% bed capacity, which would be within national guidelines.
- Short and long-term planning difficulties for the unit were ongoing due to the uncertainty of finances and trust wide service planning. There was a plan in place for the latest expansion plan for the unit that was awaiting financial approval.

Meeting people's individual needs

- There were adequate facilities in the unit to allow access and use by disabled patients, including wide corridors.
- Information leaflets about services available and discharge advice were readily available in the department. Leaflets could also be provided in different languages or other formats, such as audio, if requested.
- Staff told us that they could access a language interpreter if needed and were able to show us how they would do this. This was provided in a variety of methods including face to face and telephone interpreting and written translation.

- Access to psychiatric support was readily available from the rapid assessment and interface discharge (RAID) team, which was provided by a neighbouring trust.
- Staff could access appropriate equipment, such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity).
- There was a pathway for patients living with dementia, which guided staff on how best to treat and meet the needs of these patients. There was also a trust wide strategy to guide the care provided to patients living with dementia.
- Staff received mandatory training in dementia and how to care for patients living with dementia.
- Critical care standards recommend that patients receiving rehabilitation are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of five days a week, at a level that enables the patient to meet their rehabilitation goals. The unit was not compliant with this standard due to staffing and time constraints. There had been a 20% increase in referrals in the last two years. Respiratory physiotherapy was being prioritised over musculoskeletal therapy.
- A survey amongst patient relatives revealed a 98% dissatisfaction rate about the facilities available to relatives waiting to see their loved ones on the unit.
- On ward 2A, patients were brought to the ward after recovery for neurosurgery. There was a lack of understanding of the potential level of care required by patients expected on to the ward. This meant that correct staffing to meet those needs lacked planning.
- We raised the issue with the Matron of the neurosurgery wards. They assured us that there were daily meetings, each morning, with the nurse in charge of the ward. During these meetings a proforma was completed to identify patients who would be returning from theatre who would probably need increased observations and any step-down patients from critical care who had been identified as ready for discharge at their 8am meeting. Staffing and bed allocation was arranged across the surgery wards to allow for any increased acuity of patients on ward 2A. In addition, there was an escalation plan in place should the acuity of any patients increase during the shift or if any further patients were identified for discharge from critical care.

Access and flow

- Patients could be admitted to the critical care services via the Emergency Department or from operating theatres, wards and departments across the hospital. Admission to critical care services was guided by the trust's admission and discharge policy, with all admissions needing to be discussed between the referring team and the critical care consultant.
- Intensive care standards determined that patients should be admitted to intensive care within 4 hours of the decision to admit. This was not formally audited by the trust, but an audit of performance against the national standards stated that this was generally achieved due to the ability to escalate patients to the theatre recovery area.
- A consultant reviewed patients within 12 hours of admission, which was in accordance with national standards for intensive care services.
- Delayed discharges greater than 4 hours were reported via ICNARC (Intensive Care National Audit and Research Centre). The number of delayed discharges across the critical services was 2083 between April 2013 and March 2016. This was out of a total of 2926 admissions to critical beds across the service. This meant that 71% of patients admitted to the critical units experienced a delay in their discharge.
- An audit in April 2016 showed that 1791 hours were lost to delayed discharges. This was an increase from our last inspection in 2014 (an audit in April 2014 showed that 1143 hours were lost due to delayed discharge).
- The trust had introduced a Discharge Co-ordinator to the critical care service in August 2016 to facilitate complex, multi-speciality discharges. However, most of the delays were attributed to the capacity of receiving wards during the peak discharge time of 6pm – 7pm.
- Delayed discharges of greater than 8 hours (7.3%) were also reported and were higher than the national average , which was 5.2%.
- Out of hours discharges from the unit were much lower than the national aggregate, with the last reported figures (from April 2015 to March 2016) being 0.98% against a national aggregate of 2.8%.
- The standards for critical care units state that patients should not be transferred to other critical care units for non-clinical reasons. Crude non-clinical transfers to other critical care units were below the expected range for the unit at 0.07% against a national aggregate of 0.5%.

- NHS England data showed bed occupancy levels between January 2016 and March 2016 was lower than the England average of 85%. However, between April 2016 and June 2016 bed occupancy levels were consistently higher than the England average of 85% and peaked at 98% in April 2016. When bed occupancy rates above 85%, this can cause increased pressure within an inpatient area and can increase the risk of harm to patients in those areas.
- The trust had made long-term plans to reduce the bed occupancy rates by planning an expansion to the unit with increased bed numbers. However, agreement and funding for the plans was still awaited. An annual 5% increase in bed demand was predicted. In the shorter-term, there was a plan to open a further four beds in Area 4 when Nursing staffing figures were increased. In addition, when bed capacity limits were reached, there was the facility to open up Area 5 of the critical care unit into the theatre recovery area and use the beds in there as critical care beds on a temporary basis. The trust had no longer been monitoring how often this happened, but we were told that it happened fairly frequently and they had resumed an audit of the frequency.
- There was a trust wide and hospital specific escalation policy and plan in place for use in times of increased pressure. This was available to staff via the trusts intranet site.
- Two beds were reserved on a daily basis for emergency admissions, but the average admission rate was 2.6 patients per day at the time of our inspection.

Learning from complaints and concerns

- Complaints were handled in line with trust policy and were resolved locally wherever possible.
- Information on how to raise a complaint and contact details for the Patient Advice and Liaison Service was displayed in visitor areas on the unit.
- Staff were aware of the complaints procedure and escalated any complaints received to the Matron to deal with at the earliest opportunity. Similarly, if a complaint was received through the Patient Advice and Liaison Service (PALS), they would contact the Matron to see whether this could be resolved informally at a local level.
- The trust recorded complaints on the trust-wide system. Complaints were logged onto this system and acknowledged by the trusts customer service team. The trust expected all complaints to be acknowledged within three working days of receipt. In 2015/16 the trust met this standard in 98.5% of cases.
- A local complaints tracker was kept to monitor the progress of any investigations and responses against the timescales required in the policy and any liaison with PALS.
- In the four months before our inspection, no formal complaints had been received about the critical care unit. The few informal complaints received had been resolved by early face-to-face meetings.
- Feedback and lessons to be learnt from complaints was fed back to staff at the earliest opportunity and training needs for individual staff or groups of staff were identified from the complaints tracker.
- The Medical Director met with the Nursing Director on a weekly basis to examine any complaints that had been graded as most serious (level 3) formal complaints. They tracked how any investigations were progressing against timelines and ensured that lessons learnt were drawn up and disseminated appropriately.

Are critical care services well-led?

Good

At the previous inspection in July 2014 we rated well led as good. We have maintained this rating following this inspection because:

- The trust's vision and values were clear and staff were aware of these.
- There were good governance frameworks and managers were clear about their roles and responsibilities.
- Risks were identified, monitored and there was evidence of action taken, where appropriate.
- There was clear leadership in the service and staff spoke positively about their leaders.
- There were areas of innovation and leaders within the services were working to continually improve services.
- Staff were positive about the culture within the service and the level of support they received from their managers.

However,

- Staff told us that middle managers did not communicate important messages in a timely manner.

- Sickness rates for nursing staff in critical care were consistently above the trust target of 4.2%.

Leadership of service

- The critical care unit was part of the Medical Division, which was split into three further divisions: acute medicine, specialist medicine and long-term conditions. The unit was incorporated into the sub-division of acute medicine. The service had only recently moved into this division following a reorganisation of the divisional services and structures.
- The Medical Division as a whole had a medical director and associate medical directors who were responsible for horizon scanning (a systematic examination of information to identify potential threats, risks, emerging issues and opportunities), working with local GPs on the local health economy and clinical directors who were responsible for various hospital departments.
- The divisional structure had a divisional medical director, divisional director and a head of nursing. These three senior staff worked together to ensure the smooth running of the division across the medical, nursing and operational aspects. The division also had three business managers who were responsible for the operational aspects of the division.
- A matron with responsibility for the Critical Care Unit based at Chorley and Preston Hospitals was also in place and reported directly to the head of nursing for the division. There were a number of senior and junior sisters who rotated through to the Chorley site but were predominantly based in the Critical Care Unit at Preston Hospital. However, a band 6 level sister was present at the Chorley site 24 hours a day, seven days a week.
- The Critical Care Units had a designated clinical director and a lead consultant for Intensive Care who were responsible for leading the medical staff and the service planning of the unit.
- The leadership in the division and unit reflected the vision and values set out by the trust. Staff spoke positively about their managers and leaders.
- Leaders had clearly defined roles and were visible, respected and competent in their roles.
- The trust had an active leadership programme and we were told that candidates undertook projects as part of the course and the course was challenging.
- There were clearly defined and visible leadership roles in the department.
- Medical staff told us their senior clinicians supported them well and they had access to senior clinicians when they required.
- The medical director worked in Critical Care for one day a week as a consultant so did not lose touch with what was happening in their specialised area.
- Staff told us that the trust leadership was visible and executives, including the Chief Executive, were friendly and approachable.
- The Chief Executive of the trust regularly undertook a "Back to the Floor" role where they worked with a different hospital team for a day, for example, porters, catering staff and medical device technicians. They produced a Friday message for staff in the trust to keep them informed of headline news and there was a regular "Team Brief" for staff.
- However, staff in focus groups told us that they felt that there were communication issues with middle managers not communicating important messages in a timely manner. The executive team told us that this had been recognised and a leadership course had been written specifically for middle managers.

Vision and strategy for this service

- The trust had set of values based on five key areas, these were care and compassion, recognising individuality, seeking to involve, team working and taking personal responsibility.
- The trust has devised an acronym (a word formed as an abbreviation from the initial components in phrases or words) to help staff understand the values and apply them to their day to day working lives. The acronym was: 'ALWAYS', reminding staff to: "Ask your opinion"; "Listen to you and involve you in decisions about your care"; "Welcome you and show you respect"; "Assist and care for you"; "Treat you as you would like to be treated" and "Be sensitive to your individual needs".
- These values were displayed prominently around the hospital site and on the trust's intranet pages.
- Staff were aware of these values and embodied these values in the behaviour we observed during the inspection.

Governance, risk management and quality measurement

- The medicine division had recently been restructured and covered three specialities: acute medicine, long term conditions and specialist medicine. Medical

specialities along with emergency medicine, paediatrics and critical care were within the division. Some data provided by the trust was collated as a whole division and therefore it was difficult to monitor the performance of specific areas, for example: with regards to training and reporting incidents.

- Senior managers attended monthly divisional safety and quality executive committee meetings. The agenda included governance issues, including the safety and quality dashboard, divisional risk register, complaints and patient experience, with actions assigned to individuals as outcomes. However, there were no timelines documented, which meant it was difficult to track progress.
- There was a robust governance framework within the service and this extended to the Chorley ICU.
- Senior managers were clear on their roles in relation to governance and they identified, understood and appropriately managed quality, performance and risk.
- There was a risk register in place and there was a clear alignment of risks recorded with what staff told us was concerning them. Managers regularly reviewed, updated and escalated the risks on these registers, where appropriate. There were also action plans in place to address the identified risks.
- There was a system in place that allowed staff to escalate risks to divisional and trust board level through various meetings.
- Job planning for consultants had improved so that from delivering a 38-week year on average from a planned 42 weeks, they were now delivering a 41.5-week year. This had saved the trust £800,000 in extra duty payments.
- All work streams throughout the trust concentrated on six key areas to report on and feed upwards through trust meetings. They had the acronym G-PRIME and this covered Governance; Performance; Revaluation; Improvement; Medical staffing and Education
- Audit and monitoring of key processes took place across the service to monitor performance against objectives. Senior managers monitored information relating to performance against key quality, safety and performance objectives through performance dashboards and meetings.
- There were monthly meetings held which included governance subjects and also a specific governance meeting and we saw minutes from these meetings.
- There were routine staff meetings for the staff working on the unit to discuss day-to-day issues and to share information on complaints, incidents and audit results.

Culture within the service

- There was an open, patient-centred culture, where staff were encouraged to raise any concerns about safety and staff were proud and positive about their work.
- Staff told us that both nursing and medical staff were approachable and able to provide them with good support.
- Records showed sickness rates for medical staff in critical care were low at around 1.7%. The sickness rates for nursing staff were higher at 9.5% on average for 2015/16. This was above trust acceptable targets of 4.2% or less. We asked the senior managers in the division to explain why the sickness rates were high for nursing staff and they told us that this was due to a number of staff unfortunately having health problems at the same time. They told us that this was a sudden increase in the sickness rate and they were confident that this was now decreasing as staff returned to work. Nursing sickness rates were at around 5.61% at July 2016 and the rates were showing a downward trajectory. The sickness was not classed as work-related. An action plan had been written to improve sickness rates.
- The average staff turnover rate for nursing staff was 9.12% (at June 2016) and 8.1% for medical staff.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them.
- The information from the surveys was used to look for improvements to the services.
- There had been some public involvement in one of the expansion projects. Patients and relatives were polled for improvement suggestions and the feedback was fed directly into the expansion brief. The public were invited to a presentation event about the proposals.
- A review of data from the CQC's adult inpatient survey 2015 showed that the trust was about the same compared with other trusts for all 11 sections. The survey looked at the experiences of people who received care at an NHS hospital in July 2015. A questionnaire was sent to 1250 recent inpatients at the trust and 501 responses were received. The survey asked questions around a number of topics, such as waiting lists and planned admissions; waiting to get a

bed on a ward; the environment of the ward; doctors and nurses; care and treatment; operations and procedures; leaving hospital and overall experiences. Sections received an overall score out of 10 and the survey showed that scores ranged from 5.4 out of 10 for overall views of care and services to 8.9 out of 10 for waiting lists and planned admissions. All scores were judged to be "About the same" (rather than better or worse) than other trusts.

- The service had also developed a patient and family support group, which gave patients and their families the opportunity to obtain support, share their experiences and talk about what they had been through. The support group held regular meetings and was initially set up with a former patient who suggested that patients may suffer flashbacks and feel the need to talk through what had happened to them whilst undergoing intensive care. Meetings were held every one to two months in the evenings or on a Saturday morning to allow as many former patients to access them as possible.
- We were told that the trust had good connections with local 6th form colleges and the Manchester Medical School at Manchester University, so they could attempt to "grow their own" future staff.
- We were told that in the near future, a "Virtual Hospital" would be online for the local colleges so that local students could study in an interactive hospital.
- The critical care service did not participate in the NHS Friends and Family test, which asks patients how likely they are to recommend a hospital after treatment. Due to the complex nature of care provided in critical care meant that patients were either sedated or unable to communicate effectively with staff. This meant that staff were not able to directly gain feedback from patients in critical care. Patients would have been asked to participate in NHS Friends and Family Tests when they were discharged to a ward. However, they did take part in a local satisfaction survey that allowed patients to provide feedback on their experiences after discharge or during follow-up appointments . The last survey, that involved views of patients' relatives, had a 98% dissatisfaction rating on the facilities available to friends and relatives in the critical care unit and highlighted the lack of space available for relatives' comfort.

Staff engagement

- Staff participated in regular team meetings led by the service matron and managers.
- Staff told us they received support and regular communication from their managers in the form of emails, daily briefings and individual interactions.
- The trust board also engaged with staff via briefings and through the trusts internal intranet site.
- The trust performed about the same as other trusts surveyed across England in the 2016 General Medical Council trainee doctor survey.
- The trust performance in the 2015 NHS Staff Survey was largely the same as other trusts. However, there were three positive findings which related to the percentage of staff working extra hours and two questions relating to harassment and bullying and two negative findings which related to effective team working and Organisation and management interest in and action on health and wellbeing. The trust had an action plan in place to address the areas identified for improvement in this survey.
- In addition to the overall staff survey, the Matron had also delivered a bespoke staff survey for critical care staff where they were invited to suggest what would make things better for them specifically on the unit. Small requests, such as the addition of a staff microwave were said to have made a big difference and staff had commented that they felt able to make them without feeling that they were complaining.

Innovation, improvement and sustainability

- Staff and managers were continually striving to improve the care and treatment patients received. An example of this was the development of a patient and family support group for patients who had previously been discharged from the units in both Preston and Chorley Hospitals and their families.
- There was a realistic and comprehensive local strategy for the service and division, including a business plan with clear objectives.
- Staff were able to suggest improvements to managers and they considered and implemented them where possible.
- Staff had carried out a sleep study on the unit with a view to improving patients' sleep, especially at night. They had used a number of techniques to improve

sleep, such as adjusting lighting and the use of eye-masks and earplugs. The study had won an innovation award at the National Nursing Times Awards [see "Outstanding Practice" for further details].

- The unit had a running club for staff to help promote and improve their health and well-being.
- The service had also introduced a specialist discharge coordinator specifically for the critical care units. This was introduced to facilitate the often complex discharges from these areas and it was hoped that this would improve patients discharge experiences.

Maternity and gynaecology

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

Information about the service

The trust offers pregnant patients and their families antenatal, delivery and postnatal care for the population of Preston, Chorley and South Ribble. The maternity facilities are based at the Sharoe Green Unit on the Royal Preston Hospital (RPH) site and at Chorley District Hospital (CDH).

Maternity services include two birth centres, delivery suite, antenatal care (outpatients/inpatient), postnatal (outpatients/inpatient), one obstetric theatre, and ultrasound facilities. The service also included community midwifery services providing antenatal care, home birth and postnatal care.

Between April 2015 and March 2016, the service delivered 4,353 babies in total.

During this period, the Chorley Birth Centre (CBC) delivered 276 babies, which was 6% of the total births. The Preston Birth Centre (PBC) opened in November 2014. Between April 2015 and March 2016, the PBC delivered 17% of the total births. The home birth rate for the same period was 87 births, 2% of the overall trust births.

Direct midwifery management includes a Head of Midwifery (HOM), one matron for the two birth centres and community midwives and another matron for complex care, which includes the maternity wards and delivery suite.

Gynaecology services are delivered at the Royal Preston Hospital site and at Chorley District Hospital. This include an early pregnancy assessment unit, gynaecology ward, Day Unit, outpatient clinics, two gynaecology theatres and a termination of pregnancies facility on the Royal Preston Hospital site. The gynaecology ward includes a 14 bedded ward area.

We visited the maternity and gynaecology departments during the announced inspection between 27 and 30 September 2016 and the unannounced inspection on the 14 October 2016.

During our visits, we spoke with 43 staff, six patients and two family members. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for 22 patients and 18 medication charts. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

Maternity and gynaecology

Summary of findings

At the last inspection in July 2014 we rated the service as good overall. Following this inspection we rated this service as Requires Improvement because:

- The system for protecting babies from abduction was not robust. Due to a shortage of electronic baby security tags, not all babies were issued with a tag on the postnatal ward. There was only one main entrance, through the antenatal ward, to get to the postnatal ward. At the time of our inspection, the main reception area was not always staffed. Visitors had access to leave the wards unnoticed. When staff were working at this desk, they did not have access to the names of the patients on the postnatal ward, therefore unable to assure us that people entering and leaving the ward were monitored. Baby security issues were raised with the trust at the time of our visit, immediate action was taken, and all babies were tagged before we left site.
- The system for recording and storing fetal pregnancy remains on the gynaecology ward was not robust. Remains were stored in clear plastic containers in a fridge that stored other samples. This fridge was not locked and there was no system in place to log in or log out remains that had been taken to the mortuary. This was immediately raised with the trust and at the time of the unannounced visit, we observed changes in practice to assure us that pregnancy remains were stored safety and sensitively. Staff had also commenced a record book in use to log in and out remains that were transferred to the mortuary.
- All staff reported a shortfall in staffing and an increasing quantity of work and activity within the service. Management told us that the midwifery staffing levels had not been formally reviewed since 2011. Staffing levels was also raised as a concern at the last CQC inspection in 2014.Although since 2014, it was noted that there had been an increase of 10 full times midwives.
- The maternity service was currently waiting for the Birthrate Plus (a national tool available for calculating midwifery staffing levels) review and report, which would calculate the number of clinically active midwives required to deliver a safe high quality service.
- Due to staffing issues and sickness absence rates, there was a heavy dependence on midwives working extra hours. The trust did not use agency staff but used their in-house bank staff on an on-going basis. Additional midwifery staffing was provided by midwives working over and above their normal working hours.
- All midwifery staffing, including community were flexed to meet the needs of the service user. Managers were aware of the staffing short and recruitment was underway; however, the current measures in place were not sustainable and insufficient to mitigate the risk of harm. Due to the pressures of work, staff morale was low but staff of all professions supported each other well to work as a team. There was a desire to provide the best care they could to the patients and the inability to achieve this led to dissatisfaction amongst midwives.
- Gynaecology beds were used on a daily basis, including weekends, for patients with other medical, surgical or orthopaedic conditions. This resulted in access and flow issues and delays in some gynaecological procedures.
- Obstetric consultant cover for delivery suite was 80 hours per week, which did not meet the recommended hours required on delivery suite (Standards for Safer Childbirth, 2007). This was recorded on the risk register and it was deemed that current arrangements were safe for women.
- There was only one dedicated obstetric theatre, set up every day for obstetric emergencies. There was lack of a second dedicated obstetric theatre. Elective caesarean sections were usually performed in one of the two adjoining gynaecology theatres, which could lead to delays of operative procedures.
- Not all staff attended annual mandatory training or received their annual appraisal
- There was some discrepancy among senior staff about what level of safeguarding training provided to staff. Management informed us that the safeguarding training agenda consisted of level two training information but they considered all midwives to have the equivalent of level three safeguarding training however, they recorded it as Level 2.
- Expressed breast milk (EBM) was not stored in a locked fridge and the storeroom door was wide

open, with door lock facilities available but not utilised. This did not assure us that EBM was stored safety in order to prevent deliberate contamination or the public accessing the EBM. Fridge temperature recordings were inconsistent, showing that some days it was checked twice a day, other days only once and at weekends sometimes not checked at all. This did not assure us that EBM was stored safety.

- The trust did not complete any risk assessment for midwives carrying medical gases in their cars and did not have a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.
- Policies and guidelines were not robustly updated. Of the maternity polices and guidelines reviewed, 30% were out of date.

However;

- Care in the Preston Birth Centre was provided in a calm, relaxed and spacious environment that had been specifically designed and equipped to support normal births. The centre comprised of four spacious en-suite birthing rooms, each with a birthing pool, specialised birthing equipment and separate family rooms.
- There were clear systems for reporting incidents and managing identified risk within the service.
- The service was proactive in learning from complaints and concerns.
- Access and flow issues on the gynaecology wards were managed well by the clinical lead who had good oversight to move patients accordingly and work flexibility across all areas.
- Daily multidisciplinary team (MDT) staff safety huddles took place. Items discussed included all clinical areas including birth centres, community services, antenatal clinic, 24-hour staffing levels and access and flow in the gynaecological wards.
- Medicines were delivered, stored and dispensed safely.
- The wards were adequately maintained and equipment was readily available and fit for immediate use. Resuscitation equipment was available and fit for use by suitably trained staff.

- We found that committed and compassionate staff delivered maternity and gynaecology services. All staff treated patients with dignity and respect. People we spoke to were positive about the care they had received.
- Gynaecology staff informed us that referral to treatment times met the national recommendations, with rapid access to clinics available.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

At the previous inspection in July 2014 we rated safe as requires improvement mainly due to a number of vacant midwifery posts; long-term shortages over a six-month period, and high sickness absence rates which had resulted in heavy dependence on community midwives, extra hours and in-house bank staff, the ratios were 1:34, we have maintained this rating following this inspection because:

- The system for protecting babies from abduction was not robust. Due to a shortage of electronic baby security tags, not all babies were issued with a tag on the postnatal ward. There was only one main entrance, through the antenatal ward, to get to the postnatal ward. Visitors had access to leave the wards unnoticed. Baby security issues were raised with the trust at the time of our visit, immediate action was taken, and all babies were tagged before we left site.
- The system for recording and storing fetal pregnancy remains on the gynaecology ward was not robust. Remains were stored in clear plastic containers in an unlocked fridge that stored other samples. There was no system in place to log in or log out remains that had been taken to the mortuary, therefore this did not assure us that sample traceability was robust and sensitive to families.
- Expressed breast milk (EBM) was stored in appropriate labelled containers, in a dedicated fridge on the postnatal ward. However, this was not a locked fridge and the storeroom door was wide open, with door lock facilities available but not utilised. Fridge temperatures were not recorded daily. This did not assure us that EBM was stored safety. This was highlighted to staff at the time of our observation.
- All staff, including management, reported a shortfall in staffing and an increasing quantity of work and activity within the service.
- Staffing issues, combined with sickness absence rates of 4.2%, showed a heavy dependence on community midwives, extra hours worked by staff and in-house bank staff being used on an on-going basis. Staff informed us that the current measures in place were not sustainable and insufficient to mitigate the risk of harm.
- Due to the pressures of work, staff told us morale was low but that staff of all professions supported each other well to work as a team. We observed a desire to provide the best care staff could to the patients and the inability to achieve this at all times, led to dissatisfaction amongst some midwives.
- There was one dedicated obstetric theatre, set up every day for obstetric emergencies. There was lack of a second dedicated obstetric theatre. Elective caesarean sections were usually performed in one of the two adjoining gynaecology theatres. Staff told us that this sometimes could lead to delays of operative procedures.
- Many staff were not up to date with mandatory training requirements. Staff reported that this was often due to increased clinical demands and staff shortages. Records showed that the maternity staff compliance rate in medical device training was 28%. The trust target was 75%.
- There was some discrepancy among senior staff about what level of safeguarding training provided to staff. Management informed us that the safeguarding training agenda consisted of level two training information but they considered all midwives to have level three safeguarding training however, they recorded it as Level 2.
- The trust did not complete any risk assessment for midwives carrying medical gases in their cars and did not have a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.

However;

- There were clear systems for reporting incidents and managing identified risk within the service.
- The wards were clean and infection rates were within expected ranges.
- Medicines were stored, dispensed and administered safely.
- The wards were adequately maintained and equipment was readily available and fit for immediate use. Resuscitation equipment was available and fit for use by suitably trained staff.

Incidents

- There were systems for reporting incidents across the maternity and gynaecology services. Staff informed us they reported incidents and were confident and

competent in doing so. They told us that they knew what to report and were able to show us how they would report an incident through the electronic reporting system.

- Two serious incidents took place in the maternity service between August 2015 and July 2016. We reviewed a summary of events for one of these incidents, relating to delays in transportation of newborn blood spot samples to the laboratory in Manchester. This resulted in 125 samples being repeated and a small number of third samples being required as a small number of second samples did not reach the laboratory either. All actions and responses were completed within a month of the incident. The newborn bloodspot avoidable repeat samples for quarter 1 in 2016/17 were down to 1.4%. The trust reported that the documentation of coding on the samples had greatly improved.
- Between June 2016 and September 2016, the gynaecology department had reported 92 incidents through their electronic reporting system. Seventy-two of these were reported as "no harm", 18 were reported as "low harm". This indicates a positive culture for the reporting of incidents. There were two gynaecology incidents reported as "moderate harm". A Root Cause Analysis was carried out to ascertain the causes and actions to prevent recurrence. All incidents were reported and reviewed in a timely manner.
- There was one serious incident reported in the gynaecology department in March 2016. This was not reported until five days following the incident. Issues highlighted included that there was no care plan evident for a period of 10 days, poorly documented handover on transfer from the orthopaedic ward to the gynaecology ward, delay in the patient discharge as waiting for a rehabilitation unit bed and lack of specific criteria and escalation plan regarding the suitability of patients to reside on the gynaecology ward from other areas of care. The action plan consisted of seven actions, all to be completed by September 2016. At the time of inspection, only three actions were completed.
- Another example of an RCA for a gynaecology level two investigation was provided by the trust. A timely review was undertaken by the trust, lessons learnt were disseminated to staff and new guidelines were implemented. The case was used as part of learning discussions for trainee doctors and consultants.
- Mortality and morbidity meetings were held regularly and all staff were invited to attend, with contributions valued and encouraged. The group was multidisciplinary and included colleagues from the paediatric team. Staff told us they were also aware of different forms of feedback, such as the risk meeting and regular newsletters.
- A weekly maternity incident review meeting took place every Friday morning. A similar meeting took place on the gynaecology unit every Thursday. During our inspection, we observed the gynaecology meeting. Staff who attended both meetings included nurses, midwives, medical staff, neonatal staff and anaesthetists and the Head of Midwifery (HOM). Staff informed us that they reviewed around 20 to 30 new incidents per week. All incidents and action plans were discussed and reviewed. However, some staff said the meetings were difficult to get to due to poor staffing levels.
- Governance leads and staff we spoke to were aware of the process for the Duty of Candour.
- Lessons learnt and "Lessons of the week" were distributed to staff and discussed at all handovers and staff huddles. We also saw evidence of this in the trust magazine for women's health and notice board displays in the clinical areas. Staff gave us examples of training events such as defibrillation updates and syntocinon pump training following reported incidents.

Safety thermometer

- Information about harm free care was displayed in both the maternity and gynaecology clinical areas.
- The HOM informed us that the displayed information in the maternity areas was specific to maternity care and included the number of post-partum haemorrhages and infections. Staff were aware of this data collection and said it was discussed at the safety huddle meetings to assess the performance of the ward.

Cleanliness, infection control and hygiene

- Obstetrics and gynaecology services had been recently placed under the new surgical division following a re-structure. An infection prevention and control update was undertaken between January and March 2016 within this division. The report stated that the maternity services had a designated lead that formed a link within the division and the Trust Infection Prevention Committee (IPC). Within their role, bi-monthly meetings were held to review local infection prevention issues.

- The infection prevention and control update stated that there had been no cause for concern for MRSA, Clostridium difficile and Norovirus infections in the maternity services between 2015 and 2016.
- The obstetrics and gynaecology departments liaised closely with the trust IPC team via the identified IPC leads to ensure there was a focus on hand hygiene, ward cleanliness, detection of infections, improved use of antibiotics and staff and patient education.
- Equipment was cleaned to a high standard; this was identified through the continued use of information labels.
- The trust reported that maternity service staff had (ANTT) training provided annually and new starters underwent this training within 1 month of commencing their post. We requested the number of staff that had completed ANTT training for the last 12 months from the trust but this data was not supplied.
- Perineal infection and caesarean section infection rate audits took place in 2016. In previous years there have been changes in response to the audit results, the current audits did not identify a cause for concern.
- The maternity unit appeared clean and tidy and each room was stocked with appropriate personal protective equipment. The gynaecology wards were clean but appeared cluttered with equipment.
- Community Midwives were provided with personal protective equipment for home births.
- During our inspection, we observed good personal protective equipment practice, whereby staff were observed to be wearing gloves or washing their hands. Hand washing facilities and hand gel were widely available to staff and the public. However, we did observe one member of staff making a bed without using the correct protective items.
- We were provided with the most recent hand hygiene and uniform audit that had taken place in the department, in August 2016. Overall, the unit scored 100%, which indicated that staff had complied with best practice. This information was displayed on the performance board between the antenatal and postnatal wards.
- Gynaecology staff informed us that, single en-suite side rooms were available for isolation of patients if required and they used personal protective equipment according to trust policy.
- MRSA screening was performed according to policy, especially for major or high-risk surgery day cases. We observed one patient under taking an MRSA screen who was appropriately isolated during our inspection.
- On the gynaecology ward, staff told us the housekeeper was available 32 hours per week. However, the on call domestic service was available whenever required.
- Infection control audits from the delivery suite showed that between February 2016 and August 2016 (excluding May and June) hand hygiene and device audits scored 100% for all months. Mattress audits also scored within the trust target of 100%.Urinary catheter assessment and monitoring audit were recorded as “not applicable” for all months.
- We were not assured that cloth curtains were systematically cleaned. We requested the cleaning schedules that were used within the trust, especially in the outpatient areas. However, we received blank templates of copies of the domestic services cleaning weekly work schedules, which were not signed or dated as complete. The template schedules did not include or mention curtain cleaning. We also requested daily and weekly cleaning audits from the trust. Again, we were provided with templates of the domestic services cleaning weekly work schedules, which were not signed or dated as complete.

Environment and equipment

- On the day of the unannounced visit, we observed that patients expressed breast milk (EBM) was stored in appropriate labelled containers, in a dedicated fridge on the postnatal ward. However, this was not a locked fridge and the storeroom door was wide open, with no door lock facilities available. This did not assure us that EBM was stored safety in order to prevent deliberate contamination or the public accessing the EBM. This was highlighted to management at the time of our visit, who assured me that they would start to address the concern immediately.
- Staff informed us that the ward housekeeper under took the EBM fridge temperature recordings. Staff told us that fridge temperatures should be recorded three times a day. However, when we observed records, it showed that some days it was checked twice a day, other days only once and at weekends sometimes not checked at all. This did not assure us that EBM was stored safety. This was highlighted to staff at the time of our observation and with the Head of Midwifery.

Maternity and gynaecology

- There was one theatre for obstetrics and two gynaecology theatres. The obstetric theatre was available and staffed for use 24 hours per day seven days per week for emergency caesarean sections. The two gynaecology theatres were used for elective and emergency gynaecology operations and as well as the elective caesarean section list. However, the concerns of gynaecology theatre cancellations were recorded on the risk register. This was due to the number of emergency cases that took priority to elective cases, lack of High Dependency Unit (HDU) beds or theatre times over running.
- Since March 2016, the risk register recorded the lack of a second dedicated obstetric theatre, as having an impact upon patient care. This risk related to the occasions when there was more than one emergency occurring within maternity, which required a procedure in theatre. This risk had been set as a priority for the year and a working group had been established. The trust informed us that although the need for a second theatre was an infrequent occurrence, the potential for this to cause harm remained high. Work was currently on-going within the directorate with the aim to improve the capacity in maternity theatre provision.
- We found evidence of daily checking and recording of emergency resuscitation equipment in the maternity unit. However, we observed inconsistency in daily checking of the resuscitation trolley in August and September 2016 in the gynaecology area.
- There was no dedicated emergency resuscitation trolley in the antenatal clinic area. However, there was a shared trolley, which was stored in the maternity assessment unit, which was nearby. Staff knew where to locate the trolley, if required for an emergency.
- Antenatal clinic (ANC) consisted of nine clinical examination rooms and two quiet counselling rooms. Medical and midwifery staff had a dedicated resource room that contained computers, phones, information leaflets and information notice boards. The midwives also had a separate office. There was a urine testing room, which contained urine testing equipment, protective equipment and safety disposal notices. ANC had a beverage bay room for staff to make hot or cold drinks for themselves or patients. There were computers, wipe clean keyboards, and phones in all the clinical rooms and staff had the use of one CART computer (mobile computer on wheels). There were two patients' toilets within the clinic area, one for disabled use. Staff informed us that men were usually directed to the toilets in the main waiting area, outside the clinic area. Examination rooms were well stocked with clinical and protective equipment, stationary and information leaflets.
- The entry doors to each examination rooms in ANC did not have any "room in use" signs however; the doors were lockable from the inside for privacy. Cloth privacy curtains were used within the examination rooms; however, they did not have any cleaning dates on them. Staff informed us that the curtains were part of an automatic cleaning rota that the domestic team were responsible for, however when we requested the cleaning rotas for the curtains, the trust did not provide this information.
- The maternity day assessment unit consisted of an open space of four upright treatment chairs and one treatment couch. The area was clean, tidy and well stocked. There were no permanent curtains between the chairs or couch. For privacy, portable curtains on wheels were readily available.
- Cardiotocography (CTG) equipment for recording the baby's heartbeat and uterine contractions during pregnancy, were readily available on the maternity wards.
- The delivery suite consisted of 12 delivery rooms of which one had a pool, one room was used as the bereavement room and two rooms were used for high-risk patients (High Dependency Unit beds).
- Equipment was clean and regularly checked. All the equipment we saw had service stickers displayed and these were within date.
- The trust's biomedical engineering team, under a planned preventive maintenance schedule, serviced equipment.
- The Preston Birth Centre (PBC) was bright, spacious, clean and well equipped. Equipment included Bradbury couches.
- The community midwives home birth equipment box was well supplied with equipment such as protective aprons and gloves, blood taking packs, emergency bleeding packs, suturing packs and equipment to assist with the delivery of the placenta.
- Community midwives delivered a clinical waste box to patient's houses that were booked for a homebirth. All

dirty clinical waste, following delivery, was securely packed into the clinical waste box and transported, back to the birth centres for disposal, in the community midwives car.
- The obstetric theatres were accessible from the delivery suite, which was on the same floor.
- There were two public lifts (on the corridor outside the main entrance to the maternity wards) and one separate lift (near the PBC) that could be used for transfer of patients from the maternity wards to delivery suite and theatres.
- Gynaecology staff informed us that their bariatric equipment, for plus sized people, consisted of one trolley and chair. If more specific equipment were required, staff would order these as part of the treatment plan for specific patients**.**
- Point of care testing for blood sugar equipment and pregnancy testing equipment was checked daily on the gynaecology ward.
- An internal trust audit follow up report for medical device usage and management identified issues with staff competency assessment levels, rating the risk as "medium". The medical devices competency assessment report presented to the July 2015 Medical Device Management Group (MDMG) shows overall trust compliance of 25%. Trust compliance target was 75%. The report recommended that staff must undertake and record competency assessments and record the completion on the central database. Divisional action plans for each department to improve the levels of competency assessment compliance should be prepared. During our inspection, medical devices maintenance list was provided by the trust. Overall, maternity staff competency and compliance was 28%. This did not assure us that staff were competent to use equipment available in their ward and department.

Medicines

- The community midwives carried portable cylinders of medical gases in their cars, when attending a homebirth. These cylinders were in appropriate carrier bags, clearly labelled and in date. When not in use, we observed that cylinders were stored on the floor, in a key coded locked room in the actual birth centre and on the floor in a key coded locked staff changing room on the ground floor at the CBC. BOC (2011) recommend that cylinders are stored horizontally.
- The trust did not complete any risk assessment for midwives carrying medical gases in their cars and did not have a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car. Guidance on the security and storage of medical gas cylinders (NHS report 2014) states that a risk assessment should be undertaken to establish the physical security requirements for the storage facility and that all of these systems and each step of the medical gas cylinder process should be written into a standard operating procedure.
- There were good systems in place for the recording, administration, storage and disposal of medicines in all areas.
- Patient take home drugs on discharge were reviewed and dispensed daily on the wards by a dedicated maternity and gynaecology pharmacist and dispensary assistant. The dispensary drug cupboards were based in a specific key coded locked room on the ward areas and this ensured that patients received their drugs in a timely manner. The pharmacy staff were based on the ward area and carried a bleep for both services. The pharmacist role also included checking blood results, obtaining patient medical and obstetric history and talking with patients about the drugs they were taking home. Drug stocks were replaced daily. The pharmacist told us that there was also a robust system in place when patients were required to medicate using their own medication.
- Staff had access to the policies and procedures for medicine administration on the hospital intranet.
- There was a system in place to ensure two doctors within the abortion service completed a HSA1 form, if patients referred themselves. Termination of pregnancy medications were administrated to patients according to the national care of patients requesting induced abortion guidelines (RCOG 2011).
- We observed that the records of fridge temperatures were recorded well in maternity areas we visited. However, there was some inconsistency in August and September 2016 for checking drug fridge temperatures in the gynaecology outpatients department.
- Community midwives did not routinely carry pethidine as pain relief for home births. There was no evidence or examples that patients had requested pethidine for a homebirth but staff were aware of controlled drugs trust policy and the safe dispensing and transportation, from delivery suite to the patients home, of a controlled drug

if required. The trust policy was discussed with the community midwives, matron and CQC pharmacist at the time of inspection to ensure it was in line with national guidance on the secure dispensing of controlled drugs within a community setting. Between the announced and unannounced visits, the trust also enquired at other maternity units as to their policies. We were assured that a safe process was in place.

Records

- At the time of our inspection storage, recording and disposal systems of fetal pregnancy remains on the gynaecology ward were not robust. Remains were stored in clear plastic containers in an unlocked fridge that stored other samples. However, all individual samples were fully labelled. This was highlighted to management at the time of inspection. The following day, a lock was sourced, by staff, for the fridge.
- There was no system in place to log in or log out fetal remains that had been taken to the mortuary, therefore this did not assure us that sample traceability was robust or sensitive to families. This was also highlighted to management at the time of inspection who started to address the concern immediately.
- At the time of the unannounced visit, we observed changes in practice to assure us that pregnancy remains were stored safety and sensitively in a locked fridge with no other samples. Fridge temperatures were recorded daily. A separate store box was available for all other specimens. There was a record book in use to log in and out remains that were transferred to the mortuary, this assured us that remains were now traceable.
- The maternity service used two different information technology (IT) systems and they were unable to communicate with each other. Individual staff had to input data separately onto both systems. The trust had recently introduced phase three of the new K2 IT system on delivery suite, which enabled information to be transferred electronically from one system to the other. However, the old IT system was still being used for antenatal bookings and Venous Thrombo Embolism(VTE) assessments. The introduction of the new computer system within the department was recorded on the risk register, which stated that the trust were unsure what difficulties the early stages of implementation would cause.
- Recording of labour and birth details were being recorded electronically on the new K2 system. Each delivery room had touch screen computers. However, the Birth Centres still used yellow hand written notes for their deliveries.
- There were clear plans of care for patients in medical and nursing records. These included antenatal assessments, referrals to other centres for specialist consultations, discussions with patients and families, discharge notes to secondary care providers and communication notes from community midwives.
- We reviewed four sets of notes following booking appointments in the antenatal clinic. Three patients were booked at 10 weeks of pregnancy or before (recommended by NICE guidelines). All notes had completed booking information, including body mass index (BMI). Risk assessments and completed care plans were seen and all notes had blood results documented.
- On the unannounced visit, we reviewed four sets of inpatients notes on the gynaecology ward. These four inpatients were outliers (or known within the trust as “sleep-out patients”) from other speciality areas such as medical, surgery, urology and orthopaedics. Risk assessments had been completed such as pain control, personal needs, position, possessions and patient education, stool charts, falls prevention and moving and handling care plans. A sleepout handover form had been developed in ensure an adequate and detailed handover was carried out before the patient was transferred from one speciality to the gynaecology ward. Three of the four sets of notes had this form completed. Transfer information sheets with SBAR (Situation, Background, Assessment and Recommendation) details were completed in only one of the four sets of notes reviewed.
- Gynaecology staff also showed us anti-embolic stocking care plan assessment forms and informed us that there were other patient risk assessments staff completed online. If these online assessments highlighted a risk, only then would a paper copy need printing out and completed in the patients notes. We also observed the pregnancy loss administration record and pregnancy loss information and support packs.
- We observed patient records departments within the antenatal clinic, where notes could be ordered and accessed easily by staff.
- In the triage unit, all calls were recorded in a diary. Staff told us that if the midwifery support assistant answered

the call, the midwife checked the advice given and countersigned the record. Three calls could be recorded on the same sheet for each patient therefore a sequence of calls could be seen easily and increasing or repeated concerns were identified.

- Records were securely stored to protect their confidentiality for patients in the maternity department. However, patient records were stored at the end of patient's beds in the gynaecology ward. Staff informed us that there had been occasions where relatives had read the notes and staff had to remove the notes away from the bed. This did not assure us that patient confidentiality was being maintained.
- During our inspection, we looked at 18 sets of patient records. Documentation in all the records was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment. Appropriate clinical risk assessments were in place within the patient's record. However, some prescription charts in the gynaecology ward were incomplete.
- The 'Child health record' (red book) was issued to mothers and advice was available on how to keep the record as the main record of a child's health, growth and development.

Safeguarding

- The security system at the main maternity entrance doors to the antenatal and postnatal wards was insufficient to protect patients and babies from unwanted visitors.
- The postnatal ward was assessed through the antenatal ward main entrance; it did not have a separate access of its own. There was an intercom system for entry but staff did not always observe the doors and reception area in the antenatal ward. We observed, in the presence of the HOM, a couple leaving the ward area with their newborn twin babies unaccompanied. Staff reported this was a frequent occurrence. Any person could exit the ward unseen by pressing the door release button. Staff told us that the reception desk was not always staffed and when antenatal staff did base themselves at the reception desk, they did not have a list of the postnatal inpatients. This was brought to the attention of the trust at the time of the inspection. The HOM informed us that she was aware of the security issues. However, this was not recorded on the risk register.
- Staff said there was a lack of availability of the baby security tags, which did not assure us that baby security systems were robust. During our inspection, we observed 11 babies on the postnatal ward and seven babies did not have security tags attached. Staff informed us that there were problems ordering new tags. This was highlighted to management at the time of our inspection. By the end of our inspection, tags had been found by staff and applied to all babies. This meant the trusts' system for protecting babies from abduction was not robust and left some babies at risk.
- Insufficient baby security tags had been appropriately added to the risk register.
- At the time of our unannounced visit, all 14 babies on the postnatal ward had security tags fitted. This data was also recorded on a database on the computer. When we reviewed this, it assured us that all babies were fitted with security tags and all tags were "active" and working correctly. Since the inspection, staff had also implemented a "Baby Tag Daily Checklist", where staff checked, twice a day, that all babies were fitted with a security tag. We also viewed a box of spare tags that contained approximately 30 reusable tags. This assured us that baby security had improved in relation to the security tags.
- Children and young people safeguarding training was available for all the midwives across the service. However, there was some discrepancy about what level the training was provided. Management informed us that the safeguarding training agenda consisted of level two training (required for non-clinical and clinical staff who have some degree of contact with children) but was considered by the service as equivalent to level three training (clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns: Safeguarding children and young people: roles and competences for health care staff, intercollegiate document, 2014). Therefore, management considered all midwives to have level three safeguarding training but they recorded it as Level 2. This was highlighted to management at the time of inspection.
- When we requested the safeguarding training agenda from the trust, we received the following information via email: "topics covered on safeguarding training in 2015:

Domestic violence and FGM, 2016: Human trafficking, 2017: Back to basics of safeguarding. There was no evidence that the trust had followed the safeguarding children and young people: roles and competences for health care staff, intercollegiate guidance (2014) level three training.

- There was good evidence of multi-agency liaison and communication for patients deemed high risk due to complex social needs. We saw evidence at the morning safety huddle that patients with needs such as substance misuse, migrants, asylum seekers, domestic abuse, homelessness and safeguarding were discussed and information was share appropriately.
- We spoke to staff on the safeguarding and enhanced vulnerable team. This team included a safeguarding nurse lead, a named midwife and three other staff who specialised in perinatal mental health, domestic abuse, substance misuse, teenagers, and patients with additional needs. They reported having close working links with the Family Nurse Partnership (FNP).
- A safeguarding champions meeting was held monthly to discuss new cases and any local, regional or national policy changes.
- The safeguarding team told us they had good links and pathways regarding notifications from emergency care regarding pregnant patients.
- A safeguarding risk assessment tool was completed at every patients booking appointment and reviewed at 28 weeks of pregnancy or any other time if relevant or necessary. This tool was associated to the continuum of need pathway (Lancashire Continuum of Care, 2016).
- Birth plans for vulnerable patients and unborn babies was a multidisciplinary approach including input from supervisors of midwives, hospital clinical staff, community midwives and Head of Physical Risk.
- All the staff we spoke to were very positive about the support and advice from the safeguarding and vulnerable patient's team and they felt well supported to manage safeguarding concerns.
- Staff informed us that patients who did not attend antenatal clinic or screening appointments were followed up by either the ANC midwives or community midwives, according to the trust missed appointments policy. If contact continued to be a concern, the midwives would contact the GP and enhanced vulnerable patients' team. However, this was not stated as an action point in the policy.
- Safeguarding information was held in a designated file, which was separate from the patients hand held records. When the patient left the hospital in the postnatal period, staff continued to undertake chronological records by accessing this file. A photocopy or scanned document of the chronology documentation was now routinely sent to the community midwifery office from the wards. After each visit, the community midwife updated the chronology on her return to base. Training was provided to community staff to ensure chronologies were updated appropriately and in a timely manner.
- Gynaecology staff informed us that they could access the safeguarding team online. Staff would notify the team regarding patients with learning difficulties. They would also inform the specialist vulnerable midwives team regarding patients involved with domestic abuse issues or Female Genital Mutilation (FGM). Staff completed a “DASH” checklist, to help identify high risk cases of domestic abuse, stalking and ‘honour’- based violence.
- A maternity safeguarding link group meeting took place monthly. Minutes from August, September and October 2016 meetings were provided by the trust. Items addressed at the meetings included homebirth guidelines, continuum of care with children’s centres and case study reviews.

Mandatory training

- Information provided by the trust showed that over the last 12 months, 13 out of 19 senior medical staff had completed their mandatory training, one staff member was on maternity leave, and four staff were booked onto future dates.
- Between September 2015 and August 2016, a variation of 65% and 91% of gynaecology staff had completed the trust mandatory training. No trust target was provided.
- For the same period, midwifery compliance for mental health training was variable between 88% and 92%.
- Antenatal screening was completed by between 93% and 98% of midwives. For post-operative interventions (curriculum not stipulated) between 94% and 98% of midwives had completed the training. There was no trust target provided.
- Training figures for maternity relating to October 2015 to September 2016 showed that 69% of staff had completed the Mandatory Study Day, 66% had completed the clinical study day and 63% had

completed the professional study day. This three-day training included moving and handling, infant feeding and safeguarding level 2 update, risk management, Supervisor of midwives (SOM) update, screening, perineal care and suturing, CTG, intravenous fluids, VTE and research updates.

- Over the previous 12 months, 66% of midwives had completed the "PROMPT"
- Over the previous 12 months, 76.19% of midwives had completed the AIMS (Association for Improvements in the Maternity Services) course. No trust target was provided. No compliance figures were provided from the trust for the obstetric team.
- From October 2015 to September 2016, CTG training completed by midwives varied from 55.4% compliance in August 2016 to 84.8% in December 2015. Between 93% and 98% of midwives had completed stop smoking training for this period. Breastfeeding training varied between 75.1% compliance in August 2016 to 91% in December 2015. Clinical moving and handling training completion rates varied from 88.8% to 92.5% of midwives for the same period.
- The trust provided us with data for three different target groups of staff who had completed New-born Life support (NLS) training.
- Between September 2015 and August 2016, midwives who had completed NLS only training ranged from 78.6% in November and December 2015 to 43.4% in April 2016. For the same period, midwives who had completed the newborn resuscitation only training ranged from 85% in November 2015 to 61.7% in August 2016. Compliance figures for all midwives who had completed either one of the training between September 2015 and August 2016 ranged from the highest rate of 86.9% in November and December 2015 to the lowest rate of 57.3% in April 2016.
- From September 2015 to December 2015, between 70% and 81.2% of midwives had completed adult resuscitation training. However, figures provided by the trust showed that between January 2016 and August 2016, compliance rate was between 43.5% and 64.3%. It was unclear if training was monitored on a rolling programme, which was reset in April 2016 (start of new financial year) or it was based on the moment in time as to the percentage of staff trained who needed to be trained.
- A simulation doll was available for resuscitation training.
- The trust informed us that between August 2015 and August 2016, 85% of midwives were compliant in children's safeguarding training. The trust target was 90%. However, there was some discrepancy about what level the training was provided. Management informed us that the safeguarding training agenda consisted of level two training but was considered by the service as equivalent to level three training.
- Adult safeguarding Level 1 training was completed by 86% of nursing and midwifery registered staff by the 31 August 2016. Trust target was 85%. Adult safeguarding Level 2 training was completed by 59% of nursing and midwifery registered staff by the 31 August 2016. Trust target was 75%.
- Mental Capacity Act training data received from the trust showed that 93% of nursing and midwifery staff had completed that training. However, there were no dates provided for when this initial training was completed.
- The trust informed us that 88% of midwifery staff had completed domestic violence training in the last 12 months. No trust target was stated.
- Some staff we spoke with confirmed that it was sometimes hard to access professional development days due to staffing levels. Staff told us they were encouraged to complete their mandatory training but clinical demands and staff shortages sometimes prevented staff from being released from the clinical areas.
- Gynaecology staff informed us that they had received training in the Abortion Act 1967 and that Termination of Pregnancy (TOP) training was competency based. However, the trust informed us that gynaecology staff training and competencies for TOP was informal and there were no training figures or compliance figures recorded or available from the trust. The RCN Termination of pregnancy Framework (2013) states that professional competencies, additional knowledge and skills required should be identified and appropriate education, training, competency assessment and continuing support/supervision should be available.
- Gynaecology staff informed us that essential and mandatory training was completed annually but e-learning requirements were more difficult to complete due to staffing levels and clinical duties.

Assessing and responding to patient risk

- An Early Warning Score (EWS) clinical audit took place in Feb 2016 to review compliance and correct use of the

National Early Warning Score (NEWS) and escalation plan for patients at risk of deterioration. Five obstetric patient notes and vital signs charts were reviewed on delivery suite. Findings showed that 80% of all information was completed. One hundred percent of vital signs were completed to calculate NEWS. NEWS calculated accurately scored 80%. There were no triggers at the time of the audit. Ten gynaecology patients' observation charts were reviewed. Findings showed that 60% of all information was completed. Ninety percent of monitoring plans were completed and followed. Ninety percent of vital signs were completed to calculate NEWS. NEWS calculated accurately scored 90%.

- A repeat EWS audit took place in May 2016. Ten gynaecology patients' observation charts were reviewed. Findings showed that 70% of all information was completed. Ninety percent of monitoring plans were completed and followed. Sixty percent of vital signs were completed to calculate NEWS. If NEWS scored greater than five, escalation policy was followed in 100% of cases. Recommendations and action plan were in place to improve practice. A repeat audit was due to take place in September 2016.
- A WHO checklist audit summary took place in trust theatres, between January and June 2016. In the obstetrics and gynaecology theatres, completion of "sign in" scored 100%. Completion of "sign out" ranged from 96.2% and 98.5%. Completion of "time out" was 100%.
- We observed that all steps in the safer surgical checklist were completed well in both the obstetrics and gynaecology theatres.
- We observed that the safer surgery checklist was present in records for patients who had received suturing for perineal tears in theatre.
- There was no dedicated High dependency Unit (HDU) room on the delivery suite for patients with high dependency needs. Staff on this unit managed and cared for patients with some additional specialist clinical needs, but not patients who required respiratory support. The anaesthetists, obstetric consultants and critical care outreach team supported midwifery staff that were looking after a high dependency patient. Management informed us that there were plans for a new training module at a near university, to trained midwives to care for high dependency patient.
- A trust wide early warning score for assessing a deteriorating patient had been adapted for maternity. Doctors told us midwives and nurses escalated the care of patients appropriately. We saw this was accurately completed.
- Paediatric doctors attended emergency caesarean sections and other births if risks to the unborn baby had been identified. Midwives told us they were quick to respond when required and were part of care planning for high-risk patients.
- There were protocols in place for the emergency transfer of patients from the either birth centres to the delivery suite at the RPH. This was facilitated using a blue light ambulance and informing the maternity emergency bleep holder at the hospital of the imminent transfer. A midwife from the birth centre would accompany the patient and handover their care giving all necessary information at the hospital.
- There were three midwives allocated to each shift and a Health Care Assistant (Band 2) at the PBC. If transfer was required to delivery suite, the midwife transferred the patient via the lift on PBC.
- Information provided by the trust showed that in December 2015 and January 2016, there were 105 births at the PBC and 29 transfer of patients to the delivery suite. Reasons for transfers were all reviewed by management and deemed appropriate. These included slow heartbeat of baby, delay in first stage of labour (delay in second stage of labour (pushing stage when baby is born), epidural (pain relief) and baby passing meconium before delivery. Seventeen patient transfers occurred during the night shift, there were 3 occasions during the times of the transfers during these 2 months where there was reduced staffing due to sickness.
- There was a clear procedure in place to ensure all patients had their scans to screen for anomalies within the Fetal Anomaly Screening programme.
- On the gynaecology ward, we reviewed three risk assessments, which were all complete and up to date. This included the MUST tool to assess nutrition, falls and skin.
- Other gynaecology online risk assessments included falls, MUST, VTE, moving and handling, bed rails and post-operative wound assessment within six hours of arrival to the ward. However, there was no risk assessments completed for patients with a history of domestic abuse.

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Midwifery staffing

- From July 2015 and June 2016, midwifery staffing remained unchanged from the previous 12 months with a birth ratio of one midwife to every 31 births. RCM and Birthrate Plus, 2011, recommend a mean national ratio of 1:29.5 births. This was also a concern that was raised at the last CQC inspection in 2014. Staffing issues were recorded on the risk register.
- Staff told us that there were staff shortages in all areas due to sickness, maternity leave, retirement, posts waiting be filled through recruitment and an increase in births since the opening of the second birth centre in November 2014. The trust informed us that current midwifery staffing numbers were based on calculations performed in 2011 and had been reported to the trust board monthly. Since then, we were informed, there has been an increase in patients using the service, changes in the model of service and an increase in complexities of conditions that meant a need to increase the midwifery-staffing establishment.
- Management informed us that the impact of the high acuity increased the risk of patients and their baby's needs not being met and that one to one care of patients in established labour was not always provided. Managers told us they were also aware of the effect low staffing numbers was having on staff sickness and staff burnout and there was a potential increase in Patient Advice and Liaison Service (PALS) and formal complaints as well as damage to the service reputation although there was no evidence of an actual rise.
- All the managers and staff described midwifery staffing as a day-to-day "challenge". The service did not use agency staff. It relied on substantive staff working overtime or extra shifts. Staffing was highlighted as a concern in the previous inspection in 2014.
- Management informed us that over the past few months, the activity and acuity within the service had increased. This had been acknowledged by the increase in reported incidents relating to shortage of staff. Staff informed us that August 2016 and September 2016 had been particularly challenging months. The escalation process has been followed and a number of times the on-call community midwives have been called to attend and support the complex midwifery model. Community midwives told us that this affected their work schedule for the following day and occasionally had to rearrange home visits.
- Management told us that no incidents had resulted in harm to patients as the escalation procedures had been put into place and movement of staff had kept patients safe.
- Management informed us that since 2015, new senior staff had been appointed and at the time of our inspection, they were aware for the need to increase staffing levels. We were informed that the division had undertaken a review of staffing from June to August 2016 using the Birthrate Plus model. The final report was due soon after our inspection and management informed us that it was clear that further investment in midwifery staffing would be required. Following the Birthrate Plus report, management informed us the plan was to present the findings to the Surgical Division and then to the Trust Board in early November 2016 when a request for an increase in investment for midwives would be made.
- After our inspection, the trust provided us with the Nursing and Midwifery Staffing and Skill Mix Report issued in November 2016. The report was based on a full review of the staffing levels across all inpatient clinical areas and a review (using Birthrate Plus) of the whole of maternity services midwifery staffing. The findings showed that there was an overall shortfall of 33 posts in midwifery. A skill mix ratio review resulted in a requirement to provide an investment into midwifery staffing. The recommendation was for 19 whole time equivalent (wte) band six midwives and 14 wte midwifery support staff. The report also stated that there was no investment required to recruit to vacancies and to create a development plan for the Gynaecology Day Unit with a view to introducing a nurse practitioner role.
- Examples of the escalation policy included staff safety huddles twice a day on delivery suite, this multidisciplinary team discussion included activity, acuity and staffing across all aspects of the service. Twice a day, there was a further analysis of the staffing, activity and acuity within the maternity service using the maternity safety tool. All staff were encouraged to report online any concerns regarding staffing including the consequences if staffing was not sufficient. These were reviewed on a weekly basis by a multidisciplinary team of midwives, obstetricians, neonatologists and if appropriate anaesthetists. However, midwives remained concerned about the effect of the staffing shortages.

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- On the day of the unannounced visit, the postnatal ward was staffed by two qualified midwives, one band 3 Health Care Support worker and one band 2 Health Care Assistant. The ward was one qualified midwife short. Staff informed us that they were concerned about the forthcoming night shift as there was only one midwife and no Health Care Support Worker rostered for duty. Staff told us that managers were aware and they were reviewing staffing across the maternity unit and would provide cover for the night shift. The patient occupancy included 14 mums and 14 babies. This included four planned elective caesarean sections for that day; one of these patients was also a diabetic whose baby would require regular blood sugar monitoring, one emergency caesarean section patient from overnight, a patient who was one day after having an caesarean section who had severe mobility problems and had to have her partner stay, two babies were receiving intravenous antibiotics, four babies were requiring transitional care regular observations and a baby who had tongue tie and who needed extra support for breast feeding. Staff were concerned about the level of care they were providing and the safety of patients. This was highlighted to the HOM on the day of the unannounced visit, who assured me that she was satisfied that the postnatal ward was safe and that the night staffing issues were being reviewed and would be resolved.
- On the unannounced visit, midwives told us that there needed to be at least three qualified midwives on duty on each shift to enable the co-ordinator to leave the ward adequately staffed and save, in order for her to attend the safety huddles on the delivery suite and to ensure all staff got their allocated break times. Staff said that currently breaks were difficult to take.
- Gynaecology staff also reported issues with reduced staffing and an increased workload. One staff member told us “that the amount of work at times was a concern”. On the unannounced visit, the gynaecology ward had the correct staff rostered on duty.
- Sickness absence rates were just below 4.2% which was the trust target across the maternity services.
- One staff member told us due to poor staffing levels “there was a potential for near misses and that staff felt vulnerable and under a lot of pressure”. She also told us that younger, newer and inexperienced staff felt much stressed and often cried at work and that all staff felt tired.
- We saw examples of community staff covering the delivery unit. Community midwives and managers told us that this had negative effects on continuity of care to their patients in the community setting and that it was possible for postnatal patients to be seen by different midwives. Staff told us that they had managed to maintain 1:1 supervision for patients in labour, but that it had been very challenging. They also informed us that they have never had to cancel the home birth service due to staffing or increased workload within the maternity unit.
- Midwives told us that they were concerned that they were unable to work within their code of practice due to conflicting demands on their time and the care of patients with complex medical needs.
- Community midwives told us a lot of their extra work was done on “good will” and they often felt too tired to work due to the demands of being on call, called out during unsocial hours and working in the maternity unit. They worried about the safety of their own practice. Midwives said they had highlighted their concerns to senior management and were told to contact the supervisor on call if any concerns or worries. However, they said that most staff do not contact the supervisor or bleep holder and “they just get on with it”.
- Staff told us that they were often redeployed to the delivery unit from the antenatal and postnatal ward, which they felt left the patients on this ward at risk due to reduced staffing levels. Staff said this concerned them as they were looking after patients undergoing induction of labour, patient following caesarean sections and babies requiring extra care.
- Staff reported they did not get their breaks and this left them exhausted however the daily activities sheet completed throughout August and September demonstrated that there were only a small minority of occasions were staff reported they had no break on shift. They told us the teamwork and desire to assist patients to have a good experience kept them coming to work; however, morale was low due to the shortages of staff. Examples were given to us about staff working over and beyond their contracted hours.
- ANC staff at the RPH informed us that a full time dedicated midwife was based at the antenatal clinic at the CDH. Three days per week, she worked on her own at the Chorley site, offering drop in appointments for patients, completing pregnancy booking appointments and managing phone calls. There were no dedicated

clinics on these days. On Wednesday and Thursdays, a midwife and a health care support worker went to the Chorley site from the Preston site to assist with dedicated clinics.
- The maternity service was part of an overall housekeeper and ward clerk recruitment drive taking place on the 1st October 2016. Management informed us that increasing the ward clerk capacity would also have a positive effect in each of the working areas.
- The role of the maternity health care support workers included taking patient blood samples, testing patients for diabetes (glucose tolerance test), taking patients height and weight, carbon monoxide testing for smokers, developing customised growth charts online for babies, breast feeding support and assisting patients with hygiene needs. Both patients and midwives said their support was essential with the shortages of midwives in most areas. Some health care support workers felt as if their job description was too generic and band two staff often felt like they were doing the same job as band 3 staff.
- The maternity service also employed one band 4 nursery nurses; however, this was not a full time post and did not involve night duty shifts. This role included completing baby observation and daily checks, taking blood samples from babies, feeding support, assisting, and supporting doctors.
- During our inspection, when we highlighted the staffing issues to senior management, we were informed that staffing issues were on the risk register and were assured that an action plan was in place to mitigate risk. This involved twice daily review of staffing and workload at team huddles, incident reporting by staff, up and coming interviews to recruit more staff including band three maternity support works to the community service and postnatal wards and band two and three Health Care assistants.
- The community midwives had a rota, which included rotating into the birth centres when they would also be the midwife on call for the community. There were two midwives and one midwifery assistant in the birth centre at night, which meant this staffing, was sufficient.
- Nurse staffing issues on the gynaecology wards were similar to the maternity areas. Senior staff told us that recruitment was “reactive by the trust rather than proactive”.
- During our inspection, GDU had only one band 6 nurse and one band 3 Health Care Support worker (HCSW) on duty. The rostered rota should have been two band 6 nurses, a band 4 HSW and a ward clerk. The gynaecology ward had the correct number of staff on duty but all three nurses were band 5. Staff told us that there should be a skill mix of band 5 and band six nurses on each shift.
- We viewed copies of duty rotas that confirmed the shortages of staff. We found that some shifts had fewer than the recommended number of actual staff on duty at the start of the shift. These figures did not include the additional resources such as community midwives
- Assistant practitioners were employed to work alongside the midwives. They worked in both the inpatient setting and could complete a range of tasks to assist midwives including breastfeeding support.
- A team of operating theatre nurses was available 24 hours per day to assist in obstetric operations. Midwives assisted with the baby in theatre, once delivered.
- The trust informed us that both Birth Centres achieved 100% 1:1 midwifery care in established labour but they had only just developed an acuity tool for those areas and had no evidence to demonstrate this at the time of inspection.
- The trust had a retirement policy in place and supported flexible retirement, retire, and return to work opportunities. The trust informed us that in the last 18 months, there were three midwives, two health care assistants and one ward clerk that had retired and returned in this period. No staff had been denied retire and return in last 18 months.

Medical staffing

- Obstetric consultant cover on delivery suite was 80 hours per week. The trust were aware that this did not comply with recommendations of Standards for Safer Childbirth 2007, which recommends 98 hours, however, the trust were monitoring this closely. Obstetric consultant cover was recorded on the risk register and it was deemed that current arrangements were safe for patients following a trust risk assessment in 2015.
- Weekly consultant hours were recorded on the maternity dashboard as 75%. This had increased from 61% the previous year. However, this current level was not in line with recommended staffing levels from the Royal College of Obstetricians and Gynaecologists (2010). This was also a concern that was raised at the last CQC inspection in 2014.

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- Since the previous CQC inspection, funding for an additional consultant had increased the cover to 80-hour consultant presence.
- The elective caesarean theatre list was held three days per week (Tuesday, Wednesday and Friday). There were usually three patients booked for each day. However, a senior consultant informed us that even though there were nine places a week allocated for elective caesarean sections, they usually preformed between 10 and 11 elective sections per week. Management and obstetric consultants informed us that there was a plan to try to increase the list to cover 4 days.
- Junior staff told us that they had access to support out of hours and had no concerns in accessing consultant support out of hours.
- We observed effective medical handovers, which were multidisciplinary and included all necessary medical staff. There was discussion about any incidents, the work for the day and any lessons learnt.
- Gynaecology staff told us that daily medical cover for the unit included one Senior House Officer (SHO) and two consultant leads.
- The Triage unit, now situated on the antenatal ward, had dedicated medical cover to review patients. Staff told us that this had improved waiting times for patients to be seen.

Major incident awareness and training

- Managers and other staff we spoke with were aware there was a major incident policy however, some staff were unaware of any role they may have within it.

Are maternity and gynaecology services effective?

Requires improvement

At the previous inspection in July 2014 we rated effective as good. Following this inspection we have rated effective as requires improvement because:

- Staff annual appraisals were not always completed.
- Maternity staff competency and compliance for medical devices training was 28%. The trust target was 75%. This was also a concern raised at the last CQC inspection in 2014.
- Trust data informed us that 49.1% of gynaecology staff had received Female Genital Mutilation (FGM) training. No trust target was given.
- Policies and guidelines were not robustly updated. Of the maternity polices and guidelines reviewed 30% were out of date. However policies were easily accessible and in line with National Institute for Clinical Excellence (NICE) and other guidelines such as the Royal College of Obstetrics and Gynaecology (RCOG).
- The unplanned home birth rate was only recorded from January to June 2016 on the maternity dashboard. This ranged from 16.7% in February and April 2016 to 66.7% in January and March 2016. There was some discrepancy among staff about how this data was recorded.
- Between July 2015 and June 2016, the induction of labour rate was 31.5%. This remained unchanged from the previous 12 months. This was above the national average rate.

However;

- The provision of the midwifery led birth centre offered patients a choice of a “normal” childbirth. Midwives attended the North West network for normality to share good practice and learn from others. This met with the Royal College of Midwives guidance on normality.
- The Local Supervising Authority Audit took place in May 2016. The findings showed the supervisors of midwives were a strong, well-established and experienced team with a sound knowledge base. The team demonstrate an innovative and patient centred approach by improving care for all patients.
- There was evidence that research studies were used in the development of guidelines and practice, for example management of reduced baby movements.
- Audits took place to monitor the quality of the service provided. There was a comprehensive maternity information system in place for collecting and monitoring patient outcomes.
- Patients received timely pain relief.
- Systems were in place to offer good support for mothers who wished to breast and bottle feed.
- There were examples of effective multi-disciplinary working in obstetrics and gynaecology services.
- Access to services seven days per week included emergency gynaecology and maternity triage.
- For TOP procedures, national legislation was followed in the completion of the HSA1 form.

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Evidence-based care and treatment

- Policies and procedures were in line with NICE/Royal College guidance. This included controlled drugs policy, post-operative nausea and vomiting in adult patients, Venous Thromboembolism (VTE) prevention and removal of Bartholin's cyst.
- Gynaecology guidelines, we reviewed, were more comprehensive and detailed than maternity guidelines, including criteria for treatment and pathways. All gynaecology guidelines were within their review date apart from one, which was being revalidated at the time of our inspection.
- At the time of our inspection we reviewed 146 maternity polices and guidelines on the trust internet. Forty-four policies were past their review date, for example telephone triage guideline and missed appointments guideline. However, when we requested the missed appointment guideline from the trust, the last review date was March 2016, the next review due was March 2018 and expiry date was March 2019. Two policies we observed on the trust intranet had no review date.
- We reviewed robust guidelines for staff such the management of breech deliveries, planning place of birth, baby heart monitoring in labour and the management of a post-partum haemorrhage.
- A Preston Birth Centre Operational Policy and Chorley Birth Centre Operational Policy were provided by the trust, which included information about recommended staffing numbers for the birth centres as well as indications for transfer, management of obstetric emergencies, discharge home process and examination of the newborn.
- Staff in all areas knew how to access policies and procedures and they were available in both written form and on the intranet.
- The trust was taking part in the four elements of the 'Saving Babies Lives' (DOH 2016) programme, which included smoking cessation intervention, baby movement monitoring, better CTG understanding, and improved detection of growth restricted babies (GROW package). This provided standardised procedures, training and tools for assessment of baby growth and birthweight.
- The trust had developed customised individual growth charts and closer monitoring of reduced baby growth through increased number of scans. This was in line with RCOG Green top guideline 2013.
- Midwives collected data for audits and did receive feedback following completion of audits.
- There was a 2016-2017 Gynaecology Forward Plan of Audits, where audits were agreed and allocated to ensure compliance against relevant NICE guidelines and to measure practice and identify where improvements were required. However, the date to be completed column was blank.
- There was also an obstetric Audit Plan, 2016-2017. However, it did not include a named auditor or person taking responsibility for the audit, audit type or date to be completed column. There was also a Trust Wide Forward Programme of Clinical Audit and Effectiveness Activity 2016-2017, which included obstetrics and gynaecology audit plans.
- A Venous thromboembolism (VTE) audit took place between January 2016 and June 2016. The trust stated that all patients who have delivered their babies should have a VTE score calculated. The notes of 25 patients who had delivered between January and June 2016 were reviewed. Out of the 25 case notes, 20 were fully compliant, corresponding to a score of 80%.
- An Induction of Labour, use of Oxytocin audit took place between January 2016 and March 2016. Of 50 sets of notes reviewed, 41 were compliant with the minimum requirements for documentation outlined in standards of best practice (NICE Induction of Labour Guidelines 2015), an 82**%** pass rate, lower than previous year's audits. Failures were mostly due to lack of maternal abdominal palpation, failing to perform the CTG when uterine contractions commences and lack of maternal observations. An action plan was implemented and the main recommendations included reducing the delays in the induction process, which were a potential cause for complaints and generate clinical incidents, continue staff training to improve documentation and performance of CTG and establish a working group to target delays in induction process.
- Staff told us that the maternity unit were trialling the use of Prostin gel only (synthetic prostaglandin, inserted directly into the vagina) to monitor if this would improve delays in induction. Previously, the unit were using both Prostin gel and Propess pessaries (a slow-release prostaglandin pessary). However, the Induction of Labour Policy remained unchanged during this trail period and stated to use both Prostin and Propess. The next review date was July 2015. Expiry date was July 2016.

- The provision of the midwifery led birth centre offered patients a choice of a "normal" childbirth. Midwives attended the North West network for normality to share good practice and learn from others. This met with the Royal College of Midwives guidance on normality of birth.
- There was evidence that research studies were used in the development of guidelines and practice such as induction of labour for patients over 35 years, self-hypnosis as pain relief in labour and prevention of pre-term labour.
- We observed research notice boards around the maternity and gynaecology areas that contained information about research projects. Some notice boards contained clinical guidelines such as reduced baby movement's pathways. We also observed dedicated and up to date diabetic and Supervisor of Midwives notice boards.
- A place of birth risk assessment audit reviewed 32 sets of hospital notes from patients who delivered in May 2015. The aim was to look to see if patients delivered in the appropriate place. Data from the audit showed that all notes audited had a booking risk assessment fully completed and documentation of requested place of birth at booking documented. It also showed that all patients delivered in the most appropriate place in accordance to their clinical situation. The main action from the audit was to educate antenatal staff on the importance of updating management plans and good documentation in relation to place of birth and any changes made throughout a patients journey throughout pregnancy and labour. During our inspection, we were assured that this was in place.
- A multiple pregnancy audit took place in May 2016. Thirty eight patients were reviewed. Multi-disciplinary core team cared for 100% of patients. All patients were seen by a consultant or a senior obstetrician and were counselled about risks of multiple pregnancy as well their care plan discussed at 16 weeks gestation. Patients with a multiple pregnancy were monitored for fetal complications accordingly. Recommendations included that all patients with a high risk or complicated multiple pregnancy have a consultant from a tertiary level baby medicine centre involved in their care and that clearly documented. Clear documentation in scan reports, a discussion to take place by 24 weeks of pregnancy with one or more members of the multidisciplinary core team about the risks, signs and symptoms of preterm labour and possible outcomes of preterm birth and that clearly documented. Staff informed us that this was currently the process of care.
- A fluid balance documentation audit took place on the gynaecology ward in May 2016. Ten sets of notes were reviewed. The outcome showed that whilst the majority of documentation remained a good standard, there was room for improvement. Ensuring amounts calculated at a minimum of four hourly, recognising and calculating the positive and negative balance of patients and correct documentation of food intake were highlighted as areas for improvement.
- Following staff training in fluid balance documentation, a repeat fluid balance documentation audit took place in July 2016, on the gynaecology ward, in order to assess the level of compliance regarding correct documentation. Eight sets of notes were reviewed. The outcome concluded that documentation at the time of the audit was excellent and recommended that continuous monitoring was carried out to ensure this level of standard continued.
- A National Early Warning Score (NEWS) documentation audit took place on the gynaecology ward in July 2016. Eight sets of notes were reviewed. The outcome showed that whilst the majority of documentation remained at a good standard there was room for improvement. Ensuring NEWS charts are fully documented correctly ensure patient safety and warning of the deteriorating patient. The audit was repeated in October 2016. The outcome showed that documentation at the time of the audit is excellent and that staff needed to ensure continuous monitoring was carried out in order to ensure this level of standard continued.
- A Falls Care Plan audit took place in May 2016 on the gynaecology ward. Five sets of notes were reviewed. The outcome stated that the majority of electronic documentation remained at a good standard; however, there was still room for improvement. The conclusion stated that ensuring care plans were commenced on paper and updated accordingly, was key to providing the best possible care to our patients. A further audit was planned be carried out in 6 months' time in order to monitor progress.
- The annual report for antenatal and new-born screening programmes was published in August 2015. Areas of achievement and improvements included the reduction in the number of new-born bloodspot avoidable repeat

samples, NIPE (examination of the new-born) trained staff and the improvement in the pathway for the management of patients with Hepatitis B. Areas for improvement included the amount of babies who received their new born examination within 72 hours. Data provided by the trust showed that from April 2015 to March 2016, 95.4% of babies were examined within 72 hours of birth. Trust target is 95%. However, staff told us that there were still delays for babies who needed discharging by the paediatrician.

- The new-born bloodspot avoidable repeat samples for quarter 1 in 2016/17 were down to 1.4%. The trust reported that the documentation of coding on the samples had greatly improved.
- For TOP procedures, we saw evidence that two doctors reviewed the documentation and signed the HSA1 form, if they agreed that the reason for the termination of pregnancy met one or more grounds of the Abortion Act 1967. Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met.

Pain relief

- Patients were offered access to various sources of pain relief, such as Entonox and pethidine. The service also provided an epidural service 24 hours a day; seven days a week to those mothers who wanted to have this method of pain relief.
- The birth centre also provided alternative pain relief such as water, Tens machines, music and aromatherapy.
- Staff informed us that 82% of patients used water as a form of pain relief at the Birth Centres. Sixty percent of patients gave birth in water, which staff felt reduced the numbers of epidurals requested.
- Pain relief was reviewed regularly for efficacy and changes were made as appropriate to meet individual need.
- NEWS (National Early Warning Score) was completed on the gynaecology ward to access patient's pain levels. The staff had a good working relationship with the pain management team would who routinely came to the wards to review patients PCA's and epidurals.

Nutrition and hydration

- Most patients we spoke with were complimentary about the meals served at the trust. People had a choice of suitable and nutritious food and drink and we observed hot and cold drinks available.
- The trust was not currently working towards the Baby friendly accreditation. The UNICEF UK Baby Friendly Initiative (BFI) provides a framework for the implementation of best practice with the aim of ensuring that all parents make informed decisions about feeding their babies and are supported in their chosen feeding method. However, the HOM had plans to implement the initiative again soon with the help of the infant feeding team.
- An action plan following the National Neonatal Audit Programme(NNAP) Report 2014 was provided by the trust. Management only approved the plan in May 2016, to implement changes to improve the quality of care. Recommendations for improvement included the breast-feeding team implementing BFI standards and monitor impact on outcomes. This was agreed but not yet actioned on the plan. The timescale for completion was the end of December 2016. The HOM told us that the main barrier was potential funding resources for the introduction of BFI and adequate staffing to lead the initiative as the breast-feeding team also led the frenulectomy clinic. BFI is a programme to improve the role of maternity services to enable mothers to breastfeed babies for the best start in life.
- Breast feeding initiation rates, recorded on the maternity dashboard between July 2015 and June 2016, showed an average rate of 70%. (UK Infant Feeding Survey 2010 showed that 83% of patients in England breastfed their babies after birth).
- There were two part-time infant feeding midwives. A lot of their work was focused on the frenulectomy (tongue-tie) clinic. This clinic ran twice weekly on the post-natal ward. Referrals were from community midwives and GPs. The specially trained midwives could perform a frenulectomy, which is the removal of a small fold of tissue in the mouth, which restricts infant feeding. This could be done immediately which negated the need to wait and increased the likelihood of successful breastfeeding.
- Assistant practitioners also provided post-natal support for infant feeding. They worked in both the hospital and community setting.

- There was a patients' kitchen on each ward where patients and partners could make hot and cold drinks and snacks.

Patient outcomes

- Data from the trust maternity dashboard between July 2015 and June 2016 contained comprehensive information such as delivery rates, bookings performed, third and fourth degree tears, smoking and breast-feeding rates, stillbirth and blood loss rates. Patient bookings by 12 weeks and six days and breastfeeding national targets were also on the dashboard. The rates were compared to the previous year's rates and coloured coded if rates had increased or decreased from the previous year.
- The elective caesarean delivery trust target was 10.2%. Between July 2015 and June 2016, this was below target for only one month. The highest month was December 2015, with a rate of 15.7%.
- The emergency caesarean rate 12.4% (national average 15.3%), vaginal deliveries including breech deliveries was 68.1% (national average for normal deliveries is 60%), instrumental delivery rate as 10% (national average 12.7%). (Hospital Episode Statistics 2016).
- Data showed that between the 12 months recorded, the planned home birth rate was between 1% and 2%. This rate increased to 3.3% in December 2015. National home birth rate is 2.3% (Office of National Statistics 2014).
- The unplanned home birth rate was only recorded from January to June 2016 on the dashboard and this ranged from 16.7% in February and April 2016 to 66.7% in January and March 2016. This was discussed with management at the time of inspection as the rise in numbers caused concern. Data provided by the trust informed us "there has been a bit of confusion over this. What it actually means is that 66% of all the home births within a particular month were unplanned. In reality, this is likely to mean that one was planned and two were born before arrival. This has not been audited by the trust".
- From December 2012 and April 2016, there were seven unplanned homebirths reported as incidents. All were reviewed and in six of the cases, staff took appropriate action at the time. The most recent incident in April 2016 was an unplanned home birth, with missed Small Gestational Age (SGA - smaller than normal growth of the baby). The importance of continuity of care and fundal height measurements (measure of the size of the uterus used to assess baby growth) as per guidelines were highlighted to staff. The severity of all unplanned home births was recorded as "no harm".
- Transfer of patients from the CBC to the delivery suite at RPH varied widely over the 12-month period recorded on the dashboard. January 2016 recorded a 3% transfer rate. However, for 6 months during this period the rate was between 10.5% and 20%. September 2015, December 2015 and February 2016 recorded rates between 30% and 32%.
- Transfer rates from the PBC ranged from between 11.4% to 27% over the same 12-month period. We discussed the wide variations of transfer rated with management at the time of inspection and were informed that each transfer was recorded and reviewed and no main theme or trends had emerged.
- Midwifery led deliveries rates had increased from 17.9% in the previous 12 months to 24.2% between July 2015 and June 2016. This was largely due to the opening of the PBC in November 2014.
- In the same period, instrumental deliveries were down from 11% to 10%, teenage deliveries were down from 4.5% to 3.3%, breast-feeding rates had slightly increased to 70.4% and smoking at delivery rates had reduced to 10.8%.
- Between July 2015 and June 2016, the induction of labour rate was 31.5%. This remained unchanged from the previous 12 months. This was above the national average rate. The NHS Maternity Statistics, England: 2013-14, stated that the national induction rate was up by 1.7% to 25.0%. This recent upward trend maybe due to the introduction nationally of care bundle packages and research projects to monitor baby's heart rate and movements more closely, with the aim to reduce the number of stillbirths. The trust was involved with this care pathway but it was unclear if the trust induction rate reflected this upward trend.
- Booking patients before 12 weeks and 6 days was only above 90% in two of months between July 2015 and June 2016. NICE guidelines (2008) recommend that ideally patients should be booked around 10 weeks of pregnancy. This data was not provided on the dashboard.
- Third and fourth degree perineal tears were recorded as a combined rate on the dashboard. It showed a slight increased from 3.9% in the previous 12 months to 4.5% between July 2015 and June 2016. The dashboard did

not specify if these were primiparous patients (first time mothers) or multiparous patients (who had deliveries before). The proportion of third and fourth degree perineal tears among vaginal deliveries ranges from 1.8% to 5.1% depending if the patient was a primiparous or multiparous patient (RCOG 2016).

- From April 2015 and March 2016, the total number of third degree perineal tears for CBC was 1.7%. There was no fourth degree tears recorded. For the same period, the PBC had a 2.9% third degree tear rate. Fourth degree tears were recorded as 0.4%. This was within national recommended rates.
- The PBC also had an episiotomy rate of 1.3%. This was below the national average rate (RCOG 2016). An episiotomy is a surgical cut in the muscular area of the perineum, to help with the delivery of the baby.
- Between July 2015 and June 2016, the stillbirth rate was 0.4%. This was down from 0.6% in the previous 12 months. This was below the national average for stillbirths in the UK.
- Between July 2015 and June 2016, postnatal inpatient VTE risk assessment rate has increased to 86% from 46.6% in the previous 12 months. 11 months recorded above 90%, however there was no data recorded for June 2016.
- From April 2015 to March 2016, there were 100 maternal postnatal readmissions: 88 to Delivery Suite and 12 to the Maternity Ward. Ninety five patients stayed until at least the next day. This did not include babies' readmissions as these were recorded on the children's ward. The trust informed us that the reasons for these readmissions would only be available by reviewing all case notes, therefore, themes and trends were not readily available.
- Other data from the trust showed that January 2016 and September 2016, there were 13 maternal readmissions reported on the trust incident reporting system. The main reasons for the readmissions were sepsis, post-natal bleeding, wound infection, incorrect administration of paracetamol and inconsistent advice and follow up of a postnatal patient. Root cause analyse were performed on all readmissions and acting plans were implemented. It was unclear if there was an actual reduction in the numbers of maternal readmissions between April 2015 to March 2016 and January 2016 to September 2016 or if not all readmissions were reported on the incident reporting system for the early period.
- An audit of multiple pregnancies took place in May 2016. The maternity department met guideline standards and the teams were commended for their work. One action plan implemented was for a discussion surrounding the risks of complications of twins such as premature delivery. These discussions were now held with the patient at 16 weeks of pregnancy and a "Tamba" charity leaflet was given. Tamba is a UK charity providing information and support networks for families of twins and more babies.

Competent staff

- Maternity staff appraisal rates, up to the September 2015 to September 2016, showed that only 54% of staff had their annual appraisals completed.
- Ninety-two percent of rotational midwifery staff and 93% of specialist midwives had their appraisals completed, however; only 14% of CBC staff, 19% of PRH ward staff and 20% of the maternity support team had their annual appraisals completed. The trust target was 90%.
- One senior staff member told us that she had 14 staff members and that she had only completed two staff appraisal this year. An appraisal gives staff an opportunity to discuss their work progression, professional and personal development and future aspirations, objections and goals. This did not assure us that staff development was discussed and reviewed appropriately.
- From August 2015 to August 2016, there were 41 gynaecology nurses employed at the trust. Only 30 of these nurses had completed their annual appraisal, which was a compliance rate of 73%. One hundred percent of gynaecology specialist nurses at CDH had completed their annual appraisal; however, only 57% of specialist nurses at RPH had completed their annual appraisal.
- Data provided by the trust showed that maternity staff competency and compliance for medical devices training was 28%. The trust target was 75%.
- Some staff rotated around different areas of work. There was an integrated service between the community midwives and the two birth centres. Community midwives were rostered to work shifts on the births centres as well has provide community services. Some midwives felt this reduced the continuity of care within the community service.

- Dedicated theatre nursing staff worked in the obstetric theatre. Midwives did not scrub in theatre; they were allocated to accompany the patient to and from the theatre and help with caring for the baby when delivered.
- There were sufficient numbers of supervisors of midwives within the hospital. The role of the supervisor is to protect the public through good practice. They monitor the practices of midwives to ensure the mothers and babies receive good quality, safe care.
- The Local Supervising Authority Audit took place in May 2016. The findings showed the supervisors of midwives were a strong, well-established and experienced team with a sound knowledge base. The team demonstrate an innovative and patient centred approach by improving care for all patients. The team continued to build strong links with clinical governance and were appropriately reviewing serious incidents, conducting supervisory investigations and liaising appropriately with the LSA.
- The service had several specialist midwifery roles that led in specific clinical and non-clinical areas of practice, such as antenatal and new-born screening, IT, audit, training and development, clinical governance and risk, service development and project midwife and a consultant midwife specialising in "normality'.
- The specialist screening midwife was also trained to scan pregnant patients, two days per week.
- Preceptorship periods (to guide and support all newly qualified practitioners to make the transition from student to develop their practice further) were offered to all new staff. New midwives were also offered a trust orientation pack. New staff were reviewed and revaluated after six months to assess competencies and address any concerns or needs.
- Gynaecology staff followed trust guidelines regarding the management of miscarriages below and above 12 weeks of pregnancy.
- The trust informed us that gynaecology staff training and competencies for Termination of pregnancy (TOP) was informal and there were no training figures or compliance figures recorded or available from the trust. The RCN Termination of pregnancy Framework (2013) states that professional competencies, additional knowledge and skills required should be identified and appropriate education, training, competency assessment and continuing support/supervision should be available.
- Trust data informed us that 49.1% of gynaecology staff had received Female Genital Mutilation (FGM) training; however, no specific training dates were specified by the trust for when this training occurred. The trust stated that staff who had not received full training due to ward pressures had been shown where the resources were and how to go about reporting FGM. FGM training was only available on mandatory study days held in 2015.
- We requested data from the trust regarding Manual Vacuum Aspiration (MVA) training for termination of pregnancy. The response stated, "The actual procedure is being carried out by two consultant gynaecologists, both these practitioners have had training elsewhere"
- There was an MVA forum meeting where experienced and new practitioners met to discuss different and developing techniques. One senior doctor (ST7) had also attended a Royal College MVA course and was due to complete their practical training under trust supervision. The trust informed us that they had started training other consultants and junior doctors, who would carry out the procedure under supervision and would be "signed off" when they achieve competence. An afternoon training session, later in the year, would be held for junior doctors and nurses who would become involved in delivering this service. The trust had started auditing their procedures and outcomes as the uptake of the procedure by patients were rising".

Multidisciplinary working

- Multidisciplinary teams worked well together to ensure coordinated care for patients. From discussions with members of the multidisciplinary teams, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.
- We saw evidence of clear multidisciplinary working across all professional groups, such as the critical care outreach team on delivery suite, the endometriosis and oncology clinics in gynaecology.
- Staff safety huddles took place twice a day at 09:15 am and 7:30pm on delivery suite to discuss staffing, workload including number of elective caesarean sections and patients admitted for induction of labour. Staff who attended this included midwifery coordinators, matrons, obstetric staff and neonatal staff.
- A multidisciplinary team working approach was evident in the maternity Diabetic weekly clinics, which included specialist staff such as midwives, obstetric consultants, diabetologists, dietician and a diabetic specialist nurse.

The clinic provided a wide range of care to pregnant patients and provided pre-conception advice, care and support. The staff had recently developed a "Diabetic and Pre-conception" advice leaflet, which was in print at the time of our inspection.

- Maternity staff had been regularly asked to attend multi-agency meetings and contribute to pre-birth plans. There was good communication between the primary care and community health services.
- Members of the wider multidisciplinary team, such as maternity theatre staff, anaesthetists and student midwives, participated in multidisciplinary skills study days on an ad hoc basis to ensure a multidisciplinary approach to training.
- We saw medical and nursing staff worked well together as a team and there were clear lines of accountability and joint working.
- We observed staff handovers during our inspection. Communication between staff was effective, with staff handover and huddle meetings taking place during daily shift changes.
- On the post-natal ward, the neonatal team visited daily to assess any babies about whom the midwives had concerns and administrate intravenous antibiotics.
- Staff were complimentary and respected the roles of the specialist midwives and consultant midwife.
- Midwives provided basic stop smoking advice and Carbon Monoxide testing to patients. Referrals to help patients quit smoking were sent to the local community stop smoking service.
- Gynaecology staff told us that many of their services were nurse led but the consultants were good to work with and they had a good rapport between them.
- Gynaecology staff also reported working closely with the McMillan Nurses and adjourning cancer centre.
- Gynaecology staff told us they had good communication with GP and community midwives.
- We observed a gynaecology theatre operation and found a fully functioning multi-professional team approach, with evidence that the patient was central to the surgical process.
- Gynaecology staff informed us that they worked closely with the bereavement midwife and bereavement liaison officer. These specialist staff provided support and advice to staff and patients. They also provided pregnancy loss packs and resources to families. There was also a Chaplaincy service available to bereaved families.
- Amniocentesis invasive screening tests were performed at the trust maternity unit from 15 weeks of pregnancy. Any patients opting for a Chorionic Villus Sample (CVS) invasive screening test were referred to a tertiary referral centre in Manchester. There were 22 patients referred between 2014 and 2015.

Seven-day services

- The gynaecology day unit was open from 8am to 7pm, Monday to Friday. Emergency patients were reviewed on the gynaecology ward at weekends. Referrals were taken from the emergency department, GPs and patients could self-refer to the unit. Patients could also ring in for advice.
- The Early pregnancy assessment unit provided scan facilities five days a week, in a dedicated scan room, on the gynaecology unit.
- The gynaecology service also provided a "HOT" clinic, providing four afternoon appointments to patients, who could refer themselves.
- As part of a six-month pilot scheme, the four-bedded maternity triage was based on the antenatal ward from 8am to 10pm seven days per week. The pilot was in response from staff complaints and patient feedback and the aim was to improve waiting times and patients experience, while easing the pressure on the delivery suite staff. The doctor on call for the wards was also on call for triage.
- Outside these hours, the service was transferred to a two-bedded area on the delivery suite. This meant patients had 24-hour access 7 days per week to both telephone advice and physical assessment services.
- The maternity day care unit was open Monday to Friday, 08:30am to 4:30pm. This service provided scheduled appointments to patients such as blood pressure monitoring, recording of the baby's heart rate, administration of steroid injections and postnatal checks for delivery patients whose babies were inpatients on the neonatal intensive care unit (NICU). Staff informed us that the new system of Triage being situated on the antenatal ward meant that Triage had taken work away from the day care unit. Staff were unsure of the future for the day care unit.
- Scan facilities were available in the scan department beside the maternity assessment day unit, from 9am to

5pm, weekdays. This scan department was not specially for maternity, it was used trust wide. Out of hour scan facilities were available using a mobile scan unit on the delivery suite or facilities within the main trust.
- ANC ran Monday to Friday 9am to 5pm. This clinic provided specialist clinics to patients with specific medical and obstetric conditions such as diabetes. Midwives also completed pregnancy bookings in ANC, as well as a weekly Anti D injection (to prevent rhesus disease) clinic and dating, nuchal and anomaly scans and reviews.
- There was no dedicated Fetal Medicine Unit. Patients were referred to neighbouring trusts for this speciality. However, an infertility clinic ran once a week, which was led by a consultant from a larger neighbouring trust.
- The birth centres had 24 hours a day midwifery cover for patients to access.
- Community midwives provided on call cover 24 hours, 7 days per week.
- Weekly smear clinics were available weekly across the Preston and Chorley sites.

Access to information

- Staff safety huddles took place twice a day at 09:15 am and 7:30pm. A special proforma was used to document the meeting and use as an audit tool. Midwifery handover took place at 8am and 8pm. Doctors handover took place daily at 08:30am. The delivery suite co-ordinator would also attend this. Lessons of the week were discussed at these handover meetings.
- A Safety and Quality Maternity Group had recently been launched to oversee quality of care, safety and improve patient experience. Notice boards were displayed in the ANC resource room. This contained information such as audit outcomes, lessons of the week, IT issues and updates, incidents, complaints and claims.
- The gynaecology ward issued a newsletter to help with communication. The top three themes on the newsletter we reviewed were mislabelling of blood samples, communication and staff attitude.
- Staff accessed a closed Facebook page, where a lot of communication and information was shared safety.
- The maternity service used two different information technology (IT) systems and they were unable to communicate with each other. Individual staff had to input data separately onto both systems. The trust had recently introduced phase three of the new K2 IT system on delivery suite, which pulled information electronically from one system to the other. However, the old IT system was still being used in some areas. The introduction of the new computer system within the department was recorded on the risk register.
- Labour and birth details were being recorded electronically on the new K2 system. Each delivery room had touch screen computers. However, the Birth Centres still used yellow hand written notes for their deliveries.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent for caesarean sections had been completed fully in the records we reviewed.
- In maternity and gynaecology theatres, we observed medical, midwifery and nursing staff speaking to patients and their partners prior to their procedures, ensuring that patients were fully consented and had a clear understanding of the procedure and process.
- Staff, we spoke with, were aware of their role and responsibility regarding the care and support of any patient who lacked mental capacity.
- A patient with a DNACPR (Do Not Resuscitate) order in place was being cared for on the gynaecology ward. Staff were fully aware of the implications and process. DNACPR orders are written instructions from a physician telling health care providers not to perform Cardiopulmonary Resuscitation (CPR).
- Consent forms, we reviewed on the gynaecology unit, were completed.

Are maternity and gynaecology services caring?

Good

At the previous inspection in July 2014 we rated caring as good. We have maintained this rating following this inspection because:

- Midwives and nurses on the gynaecology ward were respectful, caring and considerate to patients and their families.
- Patients were complimentary about staff and the care they had received. They described midwives and maternity support workers as very caring, considerate, helpful and kind. They recognised they were very busy but said the care they received was good despite this.

There was recognition by staff of patients who may need additional emotional support and this was available from other specialists such as the bereavement midwife and Enhanced Team if required or through discussions and support at the "Births after Thoughts" clinic.
- There were facilities for partners to stay overnight at the Birth Centres. There was a dedicated bereavement room on the delivery suite, which had a sofa bed for partners to stay. There were also double bed family rooms for partners to stay on the ward areas.
- The trust performed about the same as the England average in CQC's Survey of Patients' Experiences of Maternity Services in May 2015.

However;

- At the time of our inspection, there was no evidence of a robust sensitive pathway for the storage and transport of fetal human remains from the gynaecology ward to the mortuary. However, these issues were reviewed and had been resolved at the time of our unannounced inspection visit.
- The Friends and Family Test (FFT) performance for maternity antenatal wards was slightly worse than the England average between July 2015 and June 2016. Performance for the other three maternity ward types was similar to the England average.
- There was mixed feedback from the FFT for the gynaecology wards.
- Some lack of patient dignity, privacy and sensitivity were observed due to environmental issues and position of clinic rooms and Triage area.

Compassionate care

- The trust informed us that the FFT performance for maternity antenatal wards was slightly worse than the England average between July 2015 and June 2016. Performance for the other three maternity ward types was similar to the England average.
- The maternity FFT test from February 2016 to July 2016 showed that between 83% and 95% of patients would recommend the antenatal care. Between March 2016 and July 2016, between 94% and 98% of patients would recommend the trust for birth. Between 95% and 98% of patients said, they would recommend postnatal community service. Between 88% and 98% of patients would recommend postnatal community provision.
- The trust performed about the same as the England average in CQC's Survey of Patients Experiences of Maternity Services in May 2015.
- Three patients we spoke to on the postnatal ward were very positive about the care they had received from staff.
- On the unannounced visit, a specialist midwife informed us that she had supported one of her patients though an elective caesarean section that morning. The patient had experienced two emergency caesarean sections under general anaesthetic but with the one to one support and presence of the specialist midwife in theatre, had overcome her fear and anxiety and opted to stay awake for her delivery.
- Information provided by the trust showed that the FFT in the gynaecology department, up to August 2016, showed that there were 107 responses from patients. Of those, 71 patients said they were extremely likely to recommend gynaecology service.
- One patient on the gynaecology ward told us that the staff were "wonderful" and they felt well cared for".
- The trust did not have a formal home birth satisfaction survey although there were positive comments on the friends and family test results and the comments books on the birth centres, which were reviewed during the inspection.
- We also spoke to a couple who had recently delivered at the Chorley Birth Centre, who praised the care they had received and spoke very positively about the staff.
- An audit of patient satisfaction in colposcopy clinic took place over a four-week period in November 2015. 40 patients from Chorley District Hospital (CDH) and 40 patients from the Royal Preston Hospital (RPH) completed the questionnaire. Eighty six percent of patients received written information prior to an appointment. This was down from 97% in the previous audit. Eighty six percent of patients said they received an explanation about the risks and benefits in a way that they understood. Ninety six percent said they were treated with respect and dignity and 97% said the care they received in the outpatients department was excellent, very good or good.
- Some lack of patient dignity and privacy was observed during the inspection at the colposcopy clinic in the outpatients department, due to the lay out of the environment. Patients waited directly outside the colposcopy treatment room; therefore, they could easily

hear sounds from the equipment being used. As there was no bed in this treatment area, if a patient became unwell, they would have to move into the nearby urodynamic room to be treated. This meant passing by the patient's waiting outside.
- Privacy and sensitivity issues were also observed within the triage area as this was a four-bedded bay shared area on the antenatal ward and only curtains separated cubicles. Invasive procedures and sensitive discussions could be heard through the curtains.

Understanding and involvement of patients and those close to them

- We spoke to obstetric consultants and staff that were passionate about continuously improving communication and patients experiences, which involved partners and families. Examples included recently extending partners visiting hours on the postnatal ward until 10pm and inviting and involving partners in the "Birth After Thoughts" clinic to help debrief postnatally.
- There were facilities for partners to stay overnight at the Birth Centres. There were also open visiting times while patients were on the delivery suite.
- There was a dedicated bereavement room on the delivery suite, which had a sofa bed for partners to stay.
- There were also double bed family rooms for partners to stay on the ward areas.

Emotional support

- Staff told us that advice and support for antenatal complications and termination of pregnancy was managed sensitively. However, there was no evidence of a robust sensitive pathway for the storage and transport of fetal human remains from the gynaecology ward to the mortuary. Some remains were stored in clear plastic containers in an unlocked fridge. This fridge also contained other specimen samples. There was also a lack of a robust system for logging remains in and out of the fridge and to the mortuary. This did not assure us that remains were treated in a sensitive manner. This was discussed with management at the time of inspection and a fridge lock was immediately sourced. At the unannounced visit, a new more robust system had been implemented to address the issues.
- Staff we spoke with understood the need to provide emotional support for mothers, and carried out assessments for anxiety and depression. Patients who have had complications during or following birth were offered a debrief review on the ward while an inpatient on the postnatal ward. A further appointment would be offered if required. If, at any time, mothers wanted to talk through their birthing experience, the service had a postnatal listening service. Information about how to contact the 'Birth After Thought service' was provided in leaflets available on the maternity ward. The service had a maternity bereavement midwife to support patients and their partners following the loss of their baby.
- There was adequate space and quiet rooms in the antenatal clinic, which were used to discuss sensitive or bad news with a patient. The doors could be locked from the inside, however, there were no "Do not disturb/ Room in use" signs on the doors.
- The dedicated bereavement room on the delivery suite had en-suite bathroom facilities, soundproof walls and a projector system that played comforting music and sounds and projected relaxing pictures onto a walled area within the room. Staff said this had received very positive feedback from families who had lost their babies.
- The dedicated bereavement midwife and bereavement liaison officer provided staff and patients support and advice on both the maternity and gynaecology wards. Resources such as support contact numbers and items such as memory boxes, pictures, handprints were all accessible to bereaved families in a sensitive and dignified manner, taking into consideration different cultural and religious needs. A chaplaincy service was also available to families.
- An Enhanced Support Team worked across both the maternity and gynaecology areas. This team included specialist staff in perinatal mental health, drugs and alcohol misuse, and a safeguarding midwife to provide advice and support to vulnerable patients. This team was well respected and valued across all areas and were involved with supporting staff also.
- The dedicated specialist Mental Health midwife worked within a multidisciplinary team providing support and care. A special mental health clinic ran regularly.
- Gynaecology staff told us that all local gynaecology oncology patients were assigned a key worker for support. However, staff told us that patients based at Chorley might not always see a key worker.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Good

At the previous inspection in July 2014 we rated responsive as good. Following this inspection we have maintained the rating because:

- Access and flow issues on the gynaecology wards were managed well by the clinical lead that had good oversight to move patients accordingly and work flexibility across all areas. However, the management of patient access and flow was a concern reported at the last CQC inspection in 2014 and this remained a significant challenge for managers.
- Daily MDT staff safety huddles took place. Items discussed included all clinical areas including both of the birth centres, community services, antenatal clinic, 24-hour staffing levels and access and flow in the gynaecological wards.
- Specialist midwives such as the bereavement midwife and Enhanced Support Team and specialist nurse clinics in the gynaecology service cared for individual needs and patients with complex needs.
- There had been no closures of the maternity services between January 2015 and June 2016.
- Gynaecology referral to treatment times met the national recommendations with rapid access to clinics available.
- Terminations of pregnancy (TOP) procedures were performed within the recommended two-week time scale.
- Patients were able to self-refer to the service and were able to choose where they wanted to give birth in discussion with the midwife.
- The trust had a policy for pregnant patients who were admitted to the Emergency Department (ED) or non-gynaecology/non-maternity wards
- Services were planned to facilitate access for patients from a wide geographical area.
- There were services to meet the needs of patients from differing social and cultural backgrounds and many examples of specialist services and adaptations.
- The service was proactive in learning from complaints and concerns.
- Once a day, babies received their intravenous (IV) antibiotics on the post-natal ward by neonatal staff, therefore they no longer had to leave the post-natal ward to receive IV antibiotic in NICU.

However;

- Gynaecology beds were used on a daily basis, including weekends, for patients with other medical, surgical or orthopaedic conditions. This resulted in access and flow issues and delays in some gynaecological procedures such as TOP. These patients often remained longer on the gynaecology ward than expected, therefore, effecting capacity of beds for gynaecology patients.
- Gynaecology patients were sometimes cared for in areas that were less appropriate for their care needs. Some inpatients were being nursed in the day case area at the time of our inspection and although there was toilet facilities there were no shower facilities.
- The specific escalation policy for the maternity unit was out of date. We were unable to access the trust escalation policy online. Maternity staff informed us that the antenatal ward was used for postnatal patients about two to three times per month.
- Community midwives told us that they were struggling to provide continuity of care to patients in the community when they were required work in the maternity unit when it was busy and short staffed.
- Due to only one dedicated obstetric theatre, staff informed us that some elective caesarean sections were often delayed or cancelled. Insufficient theatre capacity for elective caesarean sections was recorded on the risk register. Some patients had been nil by mouth (fasting) for periods prior to procedure being cancelled. However, there was evidence of a lack of trust oversight to the number of delays or cancellations as the trust informed us that they did not have current reportable data on this. This did not assure us that the trust had a robust system to monitor cancellations or delays or monitor closely themes and trends.
- A pilot scheme commenced in April 2016, relocating triage to the antenatal ward area. Management informed us that this had improved patient waiting times. However, the area was staffed within current staffing establishment, which staff told us was a pressure.

Maternity and gynaecology

Service planning and delivery to meet the needs of local people

- We observed smoking cessation advice and carbon monoxide monitoring being offered to patients in the ANC area. Staff were aware how to refer patients to the local stop smoking service for further advice and treatment.
- Midwives informed us that they provided the flu vaccination to staff and patients.
- Gynaecology services included many nurse led clinics and consultant clinics such as smear test clinics, colposcopy clinics, infertility clinics, pre-operative clinics, third degree tear perineal tear clinics that was midwife led and endocrine clinics.
- Community midwives told us that they were struggling to provide continuity of care to patients in the community when they were required work in maternity unit when busy and short staffed. They told us that management were aware.
- Community midwives told us about providing care in various geographical areas to help patient's access services easily. Examples such as Sure start clinic at health centres, Boots pharmacy and Tesco's supermarket
- Health Care Assistants ran phenylketonuria(PKU) and baby weight clinics weakly at local health centres. The PKU test is done to check whether a baby has the enzyme needed to use phenylalanine in his or her body. Phenylalanine is an amino acid that is needed for normal growth and development.

Access and flow

- The gynaecology ward and day unit were adjacent to each other on the same corridor and consisted of 14 inpatient beds and six-day case trolleys. However, staff reported that these beds were used on a daily basis, including weekends, for patients with other medical or surgical conditions (outlier patients). These patients were usually ready for discharge and waiting for discharge packages of care. However, staff gave us examples of patients who had deteriorated overnight (MEWS score 7) and needed more intense care, patients with dementia, and orthopaedic patients.
- Decisions to use these beds were made by the ward staff and the bed manager, no routine risk assessments were carried out. These patients were escalated to the manager of their speciality regularly and staff informed us that sometimes patients were moved late at night in order for them to be on the correct speciality ward.
- During our inspection, gynaecology inpatient numbers and capacity were stretched. We observed five outlier patients on the 14-bed gynaecology ward. Four of these patients were on the ward between 1 and 16 days.
- We requested, from the trust, the incident report and Root Cause Analysis (RCA) for the particular patient who became rapidly unwell on the gynaecology ward. The trust informed us that an incident form had been completed retrospectively as this event had not reported at the time. Subsequently an RCA had not yet been completed but was currently in progress.
- During our inspection, we reviewed the specific escalation policy for the maternity unit, which was out of date as of December 2015. The policy included the need for maternity review due to medical staff shortages, midwifery staff shortages and excessive workload and closing and re-opening the maternity unit. However, it stated, "Management of bed or nursing/support staff shortages within the gynaecology department should be managed in accordance with the trust escalation policy. However, when we searched for the trust escalation policy, the online system informed us that the file did not exist.
- Staff did inform us medical and surgical patients were reviewed appropriately by their own speciality medical teams.
- During our unannounced visit, there were 18 inpatients on the gynaecology ward. This included two medical patients and one surgical patient. All three patients had been on the gynaecology ward the day before. There was also one patient waiting on a trolley for theatre that day. Staff were also waiting to admit a patient returning from the high dependency unit (HDU). Staff told us that a discharge lounge was also used for well patients waiting for discharge home.
- We reviewed the six trolley bay area usually used for gynaecology day unit (GDU) patients. At the time, there were four trolleys and two inpatient beds. This area appeared very small and cramped. The bay had en-suite toilet facilities but no shower facilities. Staff informed us that if patients were admitted to the GDU for a TOP with the current capacity issues, they would have to be

allocated a trolley in the treatment room or scan room, which both had en-suite facilities. This did not assure us that patient' privacy, dignity and respect were maintained.

- Gynaecology staff and managers told us that they were not worried about staff competencies when looking after patients outside their gynaecology remit as non-gynaecology patients on the ward were usually low risk without complex needs.
- Gynaecology staff informed us that occasionally TOP procedures were delayed, especially at weekends, due to access problems to single rooms as a result of medical and surgical patients using the beds as part of the escalation process.
- We addressed this with the clinical lead for gynaecology at the time of inspection, who stated that the situation was not ideal and that access and flow was poor. However, it was evident that the situation was managed well by the clinical lead, as she was the manager of all three gynaecology areas, therefore, had good oversight to move patients accordingly and work flexibility across all areas.
- At the time of the unannounced visit, the gynaecology ward bed occupancy was full. This included four outlier patients: one medical, one surgical, one orthopaedic and one urology patient. The medical doctors of their speciality had reviewed three of these outlier patients. One patient, who was admitted overnight, was still waiting to be seen by the speciality medical team.
- We looked at bed occupancy across the maternity services and found that overall occupancy was within national acceptable averages. However, maternity staff informed us that the antenatal ward was used for postnatal patients about two to three times per month.
- Staff told us that there were some delays in moving patients from the induction area to the delivery suite. We were told that an action plan was in place about a change in induction of labour medication to address the issue and ensure that people were transferred to the delivery suite in a timely manner.
- Staff also informed us that there were delays in discharges from the postnatal ward due to poor staffing levels and waiting times for paediatricians to review and discharge some babies.
- Staff also informed us, that due to only one dedicated obstetric theatre, some elective caesarean sections were often delayed or cancelled. Insufficient theatre capacity for elective caesarean sections was recorded on the risk register. Staff informed us that the lack of sufficient theatre space resulted in delays of elective surgery work and that procedures were subject to cancellation. Some patients had been nil by mouth (fasting) for periods prior to procedure being cancelled. The risk register stated that this situation affects staffing and relationships on the unit. Senior staff informed us that the trust was working to identify ways in which theatre capacity could be improved.
- We requested data relating to the numbers of cancelled or delayed elective caesarean sections over the last 12 months and if there had been an audit to review any themes or tends. The trust response was that "they did not have current reportable data on this. Elective caesarean sections may be delayed due to emergency activity. We have no evidence in the incident reporting system of delays for elective caesarean sections as these are usually managed within a few hours". This did not assure us that the trust had a robust system to monitor cancellations or delays or monitor closely themes and trends.
- Data obtained from the trust showed that there was an 18% transfer rate from both the PBC and CBC to the delivery suite. Staff informed us that these had all been reviewed, there were no themes or trends established, and all that transfers were appropriate at the time.
- The TOP service was based at RPH site. Staff reported that TOP's were performed within the recommended 2-week time scale (The care of patients requesting induced abortion, RCOG, 2011).
- Data received from the trust and gynaecology staff informed us that referral to treatment times met the national recommendations, with rapid access to clinics available. Between September 2015 and August 2016, administration compliance was above 95% for nine of the 12 months. The remaining three months had a compliance rate between 93% and 94%. For the same 12 months, pathway compliance was between 98% and 100%.
- The trust reported that there were no maternity unit closures between January 2015 and June 2016.
- The lack of triage resources was recorded on the risk register due to the increase in patients attending maternity triage, which was having an impact on activity in delivery suite where it was situated. A pilot scheme commenced in April 2016, relocating triage to the antenatal ward area, where designated midwives and obstetricians were allocated. When this area was on

delivery suite only, the trust found that patients were waiting for long periods to be reviewed as staff on delivery suite prioritised patients in labour. The move of triage to the maternity ward was for a trial period of 6 months. Management informed us that this had improved waiting times. However, the area was staffed within current establishment, which staff told us was a pressure. Overnight, the triage was provided on delivery suite.

- Data provided by the trust, showed that in August 2016, 586 patients attended Triage and 88.5% of patients were reviewed within 30 minutes of arrival. In September 2016, 572 patients attended Triage and 91.25% were reviewed within 30 minutes of arrival.
- The use of a safety huddle meetings in the mornings on the labour ward involved all areas of the unit. They discussed patients, number of caesarean sections and inductions, staffing, safeguarding, all clinical areas including Chorley services, community services, antenatal clinic and support of staff for which they looked at a 24-hour period including gynaecological beds.
- Patients were able to self-refer to the service and were able to choose where they wanted to give birth in discussion with the midwife.
- The trust had a policy for pregnant patients who were admitted to the Emergency Department (ED) or non-gynaecology/non-maternity wards. Pregnant patients, with anything other than very minor injuries that were unrelated to pregnancy, should be seen in the ED and their care discussed with an Obstetrics/ Gynaecology consultant as well as the delivery suite coordinator. Pregnant patients admitted to wards outlying the Sharoe Green Unit were discussed at the multi-disciplinary delivery suite handovers and huddles, to enable the arrangement of appropriate review. However, this policy was last reviewed in December 2013 and the next review date of December 2015 was overdue.

Meeting people's individual needs

- The maternity service offered patients and their families' four different choices of place of birth. This included the two birth centres, a community homebirth service and the delivery suite at the Preston site.
- Senior midwives informed us that they worked closely with patients who requested care outside of national guidance. Specific cases were discussed at operative and obstetrician levels and a variety of evidence was gathered by staff to discuss at multidisciplinary meetings. Midwives and SOM worked closely with patients to create a suitable and safe patient care plan. This was saved and stored on the IT database for easy access for all staff. Staff gave examples where this had occurred with positive outcomes.
- We observed examples of specialist clinics such as a diabetic clinic, booking clinic, frenotomy clinic, colposcopy clinic, infertility clinic that all provided individual care to specialist areas.
- We spoke to the specialist diabetic midwife, who was passionate about giving one to one care to her patients and working across the north west region to share best practice and implement national and local up to date policies and procedures.
- We found that the service had developed clear pathways for patients with drug abuse and alcohol problems to ensure that they were able to access appropriate care throughout their pregnancy.
- The service also ran joint clinics with specialist midwives for specific conditions such as obesity and mental health issues.
- Leaflets were available for mothers to help them decide where to have their baby. The leaflets outlined the choices available for patients, including the difference between midwifery-led care, consultant-led care and options for home births or attending the birthing centre. Other leaflets were available on the unit or from the midwives on the antenatal unit.
- We saw that information was available for people whose first language was not English.
- Staff were able to describe how they would access translation services.
- After caring for a deaf patient, a member of staff set up group for deaf patients.
- Birth option appointments for patients and their partners who have had a previous traumatic experience and for patients who had had a previous caesarean section were available. Patients were referred for an appointment with the consultant midwife to discuss anxieties and options and agree a plan of care. These appointments were supported by the specialist midwife for perinatal mental health with the option to refer to other health professionals if required.

Maternity and gynaecology

- A team of specialist midwives and rotational staff provided a vulnerable patients service with responsibility for coordinating care for patients with complex social needs, including safeguarding and domestic violence.
- The role of the Public Health Specialist midwife, who was also a SOM, included public health issues such as smoking, breast-feeding, flu and whooping cough vaccinations.
- The consultant midwife ran the Vaginal Birth after Caesarean (VBAC) clinic to discuss birth options after previous having a caesarean section.
- We found that breastfeeding support was available across the service. The service had two part time designated infant feeding specialist midwives available to provide information and support about breastfeeding.
- At the time of our inspection, practice had just changed regarding the administration of IV antibiotics to babies. Babies now received one dose of their IV antibiotics on the postnatal ward at 11 am. The trust informed us that work was on-going to make this a regular practice at 11pm also, which would resolve the issue of babies leaving the ward during the day or night. This was on the risk register as a low risk as more staff were achieving competencies in antibiotic administration in the capacity of a second checker and proved a more effective use of staff as they no longer have to accompany babies to NICU. This also enabled babies to stay with their mothers, increasing bonding and preventing separation. The endometriosis service ran a telephone helpline, once a week, for patient follow up and support service.
- All the patients who had sustained a third or fourth degree perineal tear during birth attended a pelvic floor clinic, with appropriate follow-up in place.
- Gynaecology staff ran a “Health and Wellbeing” clinic where patient were able to access many different care providers such as specialist nurses, complimentary therapies, fatigue management, counselling, return to work advice and benefits advise.
- The gynaecology service offered patients interactive books developed especially for gynaecology patients.
- Gynaecology staff gave an example of support and care given to transgender patients, which included pre-planning meetings to accommodate specific requirements, while an inpatient.
- Gynaecology staff informed us that interpreter services were available via the Big Word telephone system.
- Gynaecology staff told us that they catered for a variety of different religious beliefs and had recently employed a band 3 bereavement liaison officer to support different religious customs and traditions.
- Gynaecology staff informed us about using a “passport” to assist patients with learning difficulties. Passports were designed to give hospital staff helpful information that is about not only illness and health. It can include lists of what the person likes or dislikes, from the amount of physical contact to their favourite type of drink, as well as their interests. This will help all the hospital staff know how to make them feel comfortable.
- Gynaecology staff were involved with the “Forget Me Not” programme for patients with dementia. This helps staff to understand and improve the environment and well-being of people with dementia.
- All placentas were sent, for histology following a stillbirth, to a neighbouring larger trust as routine policy. This procedure helped to provide an explanation and information relevant to the loss.

Learning from complaints and concerns

- Staff we spoke with were aware of the trust’s complaints system and how to advise patients and relatives to make a complaint, if they wished to do so.
- We found that leaflets were freely available with information on how to complain or raise concerns about the services.
- We found that the service was proactive in learning from complaints and concerns. A checklist had been developed that was sent to families after a serious incident to seek feedback from patients and their families on what happened and how the service could improve. This showed that the service was very open in responding to learning from complaints and concerns.
- Gynaecology staff gave us an example following recent complaints around patient seating opposite the main nurse desk. Staff moved the seating area to a more private area. Staff also bought mobile phones to conduct sensitive patient information conversations in areas that were quieter and more confidential.
- Following a serious incident regarding a fall in the gynaecology ward, all bathrooms that included shower

facilities had been refurbished to include safety posters, extra lighting, new emergency pull cords, non-slip flooring and two-tone colour flooring to separate the shower area from the toilet and sink area.
- Patient Advice and Liaison Service (PALS) leaflets and posters were available and visible in all the clinical areas.
- Information about supervisors of midwives and how to contact them was freely available on the unit.
- Complaints were discussed at the monthly meetings of the quality and governance committee safety huddles at shift handover.

Are maternity and gynaecology services well-led?

Requires improvement

At the previous inspection in July 2014 we rated well led as good. Following this inspection we have rated well-led as Requires Improvement because:

- Morale was low due to the pressures of work and staffing levels. However, staff of all professions supported each other well to work as a team. There was an overwhelming desire to provide the best care they could to the patients and the inability to achieve this led to dissatisfaction amongst the midwives.
- Poor staffing and reduced consultant hours were causes for concern in the last CQC inspection in 2014 and remained the same issues during this inspection.
- The Nursing and Midwifery Staffing and Skill Mix Report issued in November 2016 included a review of the staffing levels (using Birthrate Plus) of the whole of maternity services midwifery staffing. The findings showed that there was an overall shortfall of 33 posts in midwifery. This included 19 full time band 6 midwives and 14 full time midwifery support staff.
- Clinical governance and risk meetings were established but the attendance by clinical grade staff was limited and so it appeared that clinical governance was not integral to the management of safety within the service.
- The risk register was not as robust as expected with some expected parameters not included meaning that the process was not auditable.
- Leadership in maternity although improved was reported to lack visibility in some areas and that executive leads were not visible and communication from the executive felt remote.
- Community lead midwives were allocated one management day per week however; this was not protected time and was often hard to take due to busy workloads and staff shortages.

However;

- There was an obstetric strategic plan for 2016/17, which most maternity staff were aware of. There was also an obstetric business plan 2016 to 2018.
- Maternity and gynaecology clinical governance and risk meetings took place monthly where risks were discussed and reviewed.
- The service had just re-introduced the Maternity Services Liaison Committee which enables maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local patients, parents and families.
- TOP HSA1 and HSA4 forms were completed in a timely manner.

Leadership of service

- In most areas band five and six midwives told us the managers were supportive but “there was only so much the managers could do” due to the poor staffing levels.
- Staff told us the leadership of the service in most areas had improved and that senior midwifery managers were more visible now than previously. However, some staff told us that some managers were more visible than others were and some band 7 managers were poor to delegate management responsibilities to senior band 6 staff. Staff said this caused some tension and made them feel undervalued and demoralised. These staff also said direct management did not nurture their current experience and management potential and they felt they did not have a “voice” within the department.
- Some staff informed us that some team meetings were arranged by management after work time but staff did not get the time back.
- Some staff told us that professional development was not encouraged and they felt “held back and stifled” by their manager.

- Other staff informed us while the midwifery matrons were visible, the HOM was only sometimes visible in the clinical areas and they never saw the divisional nursing and midwifery lead or the Chief Executive Officer(CEO).
- There was conflicting opinion amongst the senior midwives we spoke with about the midwifery management team. Whilst some described them as "proactive" and "research focussed" with a good mix of clinical and personnel management skills, others stated there was "a lack of managerial appreciation of what was safe practice and what is not".
- Management informed us that they were proud of the way the midwives worked and repeatedly told us that even though the staffing levels were "stretched" the hospital was safe for patients. This meant there was inconsistency in the way the leadership and safety aspect of the service was viewed by staff and management.
- Staff told us they felt "stretched and stretched" and "sad and unhappy" at times". They felt "frustrated with the way things were run" but passionate about the care they gave their patients. Staff told us that peer support among the teams was good but even though management were approachable and had an "open door" policy, they felt that senior managers had "priorities elsewhere".
- Staff highlighted that support from the SOM was good.
- Senior maternity management informed us that they were part of a small maternity rota that phoned into the delivery suite every night at 11pm to assess workload and staffing. This was to support the only band seven rostered on duty overnight.
- Gynaecology staff informed us that matrons and senior management were approachable and visible. They reported an open door policy and a no blame culture. Staff felt respected, valued and care was patient centred. Staff reported, "loving their job".
- Community lead midwives told us that they are usually allocated one management day per week however; this was not protected time and was often hard to take due to busy workloads and staff shortages.

Vision and strategy for this service

- An overview of the obstetric strategic plan for 2016/17 stated the need for the development of the perinatal mental health service, the growing needs of vulnerable patients, families i.e. safeguarding and Female Genital Mutilation (FGM), the development of a high dependency unit (HDU) and triage. Main priorities also included seven day working (98-hour consultant cover) and education. Adequate consultant cover was a concern raised at the last inspection in 2014 that had yet to be resolved.
- Senior maternity management and medical clinical directors informed us that the short and middle term goals involved four main areas of focus for the development of the service: implementing a fourth caesarean section list, development of Triage unit, HDU staff training and competencies and development of the HDU area. Working groups had been identified and fed back to the directorate team. Senior management were also keen to continue to develop the two Birth Centres.
- The majority of staff we spoke to were aware of future plans for the service.
- A Quality and Improvement team was developed which consisted of the service development midwife, clinical governance and risk midwife, audit midwife, training and education midwife, the IT midwife and a band 5-administration support member of staff, with an aim to lead, implement and monitor clinical improvements and changes.
- As part of the long term vision, the service had put forward a bid for the NHS Sustainability and Transformation Plan (STP), an approach to help ensure that health and care services are built around the needs of local populations and show how local services will evolve and become sustainable over the next five years, ultimately delivering the Five Year Forward vision for better health, better patient care and improved NHS efficiency.
- Senior managers informed us that they were in conversation with the local CCG regarding funding to move toward the "Patient Knows Best" initiative by the Perinatal Institute. This involves the introduction of the "MiApp" online records system that offers mothers and healthcare professionals full access to the clinical record of the pregnancy, birth and postnatal period. MiApp puts the mother in control of her own health record and is accessible on her mobile phone, tablet or home computer. The information can be shared instantly with primary and secondary care providers and links to GP and hospital based information systems, thereby avoiding double entry of data. MiApp promotes effective communication between the mother and her carers and ensures that patients have the opportunity to be fully informed and engaged in decision-making.

- The trust informed us that the provision of MiApp would enhance the recording of safeguarding issues and sharing of this information between relevant staff. A business plan had been completed and discussions were on-going with the CCG regarding funding for a pilot project of MiApp.
- Senior management informed us that they were worried about midwifery staffing levels, staff morale and staff sickness rates. September 2016 sickness rate for qualified nurses was just below the trust target of 4.2% the trust target. Management were also aware of their ageing staff population and told us they were working with the local university to recruit their own students once qualified.
- Gynaecology staff informed us that there were directorate meetings held to discuss and monitor progress of the unit and that there were plans to commence an infertility nurse specialist role.

Governance, risk management and quality measurement

- There was a clinical governance and risk lead midwife, a governance facilitator, an obstetric consultant lead for governance and a consultant lead for gynaecology in the service.
- All maternity risks were managed and monitored by the clinical governance and risk management process at the weekly incident and risk meeting and reported to the clinical governance and risk management group monthly. All new significant and high risks were approved through the directorate processes in accordance with the Divisional Risk Strategy before being placed on the risk register.
- Between November 2015 and July 2016, monthly governance and risk meetings were well attended by the Clinical Governance and Risk Lead, Clinical and Medical Director and the HOM. However, there was poor monthly representation from clinical managers, team leaders, matrons, consultant midwife, supervisor of midwife (SOM), gynaecology leads, vulnerable midwifery team, audit lead and Birth Centre representatives. Topics discussed included risk register, high-level investigations, lessons learnt, implementation new computer system (K2), maternity dashboard and thermometer and safeguarding.
- Gynaecology governance meetings took place every second month. Between January 2015 and May 2016 (10 meetings), the gynaecology ward manager attended nine of the 10 meetings. However, there was poor attendance from other senior nursing and medical clinical leads. Topics discussed included risk management issues, guidelines, patient information leaflets, training issues, gynaecology dashboard and service development.
- The trust provided a risk management report for the period between March 2016 and August 2016. There were no high risks reported.
- Any new risks were identified by all levels of staff and this was encouraged through directorate and team meetings. The trust told us they were proactive in the identification and management of risks. However, poor staffing and reduced consultant hours were mentioned in the last CQC inspection in 2014 and still remained the same issues during this inspection.
- A working group had been established to address the potential of establishing a dedicated HDU in the delivery suite setting. A regional steering group was also in place to develop pathways and training requirements. The trust was waiting for the “Enhanced Care Report” to come out in November 2016 to inform further development. However, there had been no major incidents reported relating to HDU care provision on the delivery suite.
- The gynaecology risk register provided by the trust, had only two items recorded on it. The risk register did not have any start or review dates, actions plans, timelines for completion of any actions or a named member of staff to lead and take ownership. The rating scores were not explained nor what the previous rating was at last review.
- The gynaecology risk register included GDU escalation and the use of beds by other specialities and theatre cancellations due to the unavailability of HDU beds. Examples of action plans to improve this included “right patient – right bed” daily review by the manager.
- As part of our inspection, we were able to observe the weekly risk meeting and saw evidence of how incidents were reported and appropriate follow-up actions identified, such as a formal review or root cause analysis if required.
- The trust produced a twice yearly Maternity Service Governance Magazine which included topics such as supervision, incidents, lessons learnt, risk register, patient case summaries, audit, safety and quality updates and research.

- TOP HSA4 forms were completed by staff and submitted, within the recommended 14 days, to the Department of Health post treatment.

Culture within the service

- Staff acknowledged the challenges about staffing shortages. They felt that managers were aware of the issues and were trying to recruit more staff. However, staff generally felt there was low morale amongst the workforce and some staff told us they felt exhausted and worried once they went home at the end of a shift. There was a similar acknowledgement in the last inspection report in 2014 where staff acknowledged the same challenges about staffing levels.
- Many staff across the service spoke enthusiastically about their work and were proud of the care they delivered as a whole team. They described that there was a culture of 'good will' within the service, but staff were worried about how far that good will could sustain the provision of good patient care. This concern was also highlighted in the last CQC inspection report in 2014.
- Gynaecology staff were aware of the Duty of Candour policy and gave an example of when Duty of Candour was implemented.

Public engagement

- The service had just re-introduced the Maternity Services Liaison Committee (MSLC) meeting in February 2016. This forum enables maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local patients, parents and families. Representation at these meetings included CCG, trust, NCT, GP and Public Health. Items on the agenda included service user engagement group feedback, performance update, MSLC Facebook page, UNICEF BFI, MiApp update, birth centre updates and complaints.
- Gynaecology staff were unable to give examples of specific public engagement or any patient/public representative.

Staff engagement

- Staff told us that they did not always feel engaged as part of the trust and felt that the senior managers were aware of the issues within the services but it did not always filter down to them. This was a change since the last inspection report in 2014, where staff did feel engaged.
- Staff told us that the CEO communicated through emails to staff, encouraging the staff to ask questions to the CEO. Some staff told us that there were no staff meetings held in the trust for staff to attend to be "heard" or "voice" opinions. However, we were told by the Provider that there was a "Valuing your Voice" intranet page which allowed staff to directly access senior leadership with issue.
- Community management informed us that they held a monthly team meeting but also encouraged the teams to have their own regular meeting. However, staff said this was sometimes impossible due to clinical and staffing demands.
- A new initiative by the community manager was to hold a "share the air" half hour booked time slot on alternative months, for staff to come to discuss anything. At the time of our inspection, only one meeting had been held where no staff turned up.
- Staff informed us about some student midwives who undertook some funding events to raise money for equipment for the CBC.
- A band 7 specialist midwife was trained in counselling skills and provided support and counselling to staff. The trust also had a support agency that staff could self refer too.
- Gynaecology staff told us that staff engagement and communication was mainly through team meetings, memos or by emails.

Innovation, improvement and sustainability

- There was a 2016 to 2018 maternity obstetric business plan. In this were the aims, objectives and challenges for the next five years of the service. These were both clinical and quality objectives and challenges with an action plan of how to achieve the improvements identified. Already approved on the plan was 98-hour consultant cover and completing Birthrate Plus report. Areas to be developed included the establishment of HDU, triage, implement the Baby Friendly initiative and Fetal Medicine and additional theatre capacity.
- Managers informed us that the midwifery service has been a stretched service; however, ensuring safety of mothers and babies was paramount. Patient safety was

provided by monitoring incidents, outcomes and complaints relating to staffing. However, management acknowledged that midwives were working extremely hard to continue to provide an excellent service to mothers, babies and families which was a testament to them and but it was recognised that this was not sustainable.

- During our inspection, managers were waiting for the Birthrate Plus report in order to assess and recruit more staff. The report findings were to be presented within the Surgical Division and then to the Trust Board in November 2016, when an increase in investment for midwives would be requested.
- After our inspection, the trust provided us with the Nursing and Midwifery Staffing and Skill Mix Report issued in November 2016. The report was based on a full review of the staffing levels across all inpatient clinical areas and a review (using Birthrate Plus) of the whole of maternity services midwifery staffing. The findings showed that there was an overall shortfall of 33 posts in midwifery. This included 19 whole time equivalent (wte) band 6 midwives and 14 (wte) midwifery support staff.
- The role of the consultant midwife included service innovation, research, education and clinical roles. However, she informed us that she was soon to leave the trust. Her role was to be advertised by the trust.
- In some areas, individual staff members had been supported and encouraged to be innovative and develop practice ideas; however, they agreed that this had become difficult due to poor staffing levels, which meant their workload had increased.
- We saw several examples of research projects the service were involved with, including projects looking at inductions and reducing the risk of stillbirth. The consultant midwife worked closely with a large local university to review and set up new research studies.
- The maternity service had developed an information booklet called “your.choice where to have your baby”. This provided planning and choosing where to birth information to healthy patients who had a straightforward pregnancy. The consultant midwife informed us that this booklet was to be used by NICE on their website for national use.
- The consultant midwife was also involved with national NICE guideline initiatives such as intrapartum guidelines, continuity of care guidelines and normalising birth in medical settings – supporting delivery suite staff. She was also participated in the intrapartum high-risk guideline group and was part of the national task force for supervision.
- The consultant midwife informed us that the trust was waiting to hear if they became a site for the national Midwifery Unit Network. In collaboration with the Royal College of Midwives, the Maternity Network Unit offers support to those wishing to develop midwifery units (birth centres), and to those already established midwifery units. The network acts as a hub to share good practice and information resources, and be a community of practice with a shared philosophy essential to offer consistent, excellent and safe care for patients and their families.
- A “Maternity Unit Network Celebrating Maternity Units in Lancashire” event took place at RPH in July 2016. National leads, senior RCM representatives, consultant midwives and HOMs attended as well as a presentation from a local service user.
- In June 2016, local service users nominated midwives for the “Lancashire Health Hero’s” Award.
- The consultant midwife won the RCM national award for “Evidence into Practice” in 2015.
- Gynaecology staff were shortlisted for the RCNI Nurse Awards 2016 for their telephone follow-up service for patients with endometrial cancer.

Services for children and young people

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

Information about the service

Lancashire Teaching Hospital NHS Trust provides services to children and young people from age 0-16 years at Royal Preston Hospital, with 30 paediatric beds and a potential to escalate to 42 beds. The unit is open 365 days per year and provides a 24-hour emergency service and elective in-patient care. Some patients up to age 19 years who have long term or chronic conditions also remain under the care of a paediatrician.

The ward includes a designated Paediatric Assessment Unit (PAU), 10 isolation cubicles which can extend to provide for up to 17 admissions. There are two beds allocated for high dependency care. A children's nursing outreach team is also based on the ward, providing ongoing community care and treatment for children following their discharge, where this is needed. Children's outpatient services are provided from Royal Preston Hospital, with some additional outpatient service also provided at Chorley Hospital, two days a week. Staff advised that approximately 200 children were seen per week in the children's outpatient department, with approximately 10,000 new and 6,000 follow up appointments annually.

The neonatal unit provides 31 cots, including six intensive care cots, eight high dependency cots and 17 special care cots. This number also includes two transitional care beds for parents and babies preparing for discharge to home.

Hospital episode statistics data (HES) show there were 8,310 children and young people seen between March 2015 and February 2016. The most common primary diagnosis groups recorded for emergency admissions for the under one age group (April 2015 to March 2016) were for acute bronchitis and other perinatal conditions. The most common primary diagnosis group recorded on emergency admission for the 1-17 age group (April 2015 to March 2016) were for viral infection and other respiratory infection.

During the inspection we observed treatment and care and reviewed 19 sets of case notes. We spoke with 12 patients and their carers, also 52 members of staff, including nurses, consultants, doctors, ward managers, healthcare assistants, physiotherapists, speech and language therapists, administration staff and senior managers

Services for children and young people

Summary of findings

At the last inspection in July 2014 the service was rated as Good overall although the safe domain was rated as requiring improvement. At this inspection we rated this service as requires improvement overall because:

- Nurse staffing levels on the children's ward did not reflect Royal College of Nursing (RCN) standards (August 2013) and the ward was short staffed on a regular basis, however staff numbers were reported to senior managers on a daily basis.
- Nurse staffing levels on the neonatal unit did not meet standards recommended by the British Association of Perinatal Medicine (BAPM), with managers advising that they were 80% compliant with these.
- Paediatric early warning scores were not actioned consistently and we saw some evidence that actions were not recorded when a patient's score changed from amber to red.
- There were insufficient staff available to provide one to one nursing supervision for patients admitted for Child and Adolescent Mental Health Services. Staff reported frequent additional demands in providing for the care needs of these and other patients whose needs were highly complex.
- Staff working with children in various roles, including nursing staff, reported they had completed level two safeguarding training only, which was below nationally recommended levels for this training. In addition, the trust's training records were inconsistent with ward training records in order to accurately confirm this.
- We saw evidence that checks on emergency resuscitation equipment were not consistently documented on the neonatal unit, with checks on the emergency transfer incubators and special care emergency box incomplete
- Records in the children's outpatient department were left unsecured in an administrative area overnight, where there was potential for public access when the department was unsupervised after clinic hours.
- Appraisal rates for nursing staff did not meet the trust target on the children's ward and some nurses said they had not fully completed their preceptorship supervision.
- The children's community nursing service only provided cover during weekdays, meaning that some children requiring continued treatment after their discharge needed to come back to the ward at weekends.
- Physiotherapy services for the children's areas did not use competency tools and general physiotherapy staff who supported the on call service lacked confidence in paediatric techniques.

However;

- Risks were identified and managed through a risk register, with systems in place to share learning with staff from incidents that had occurred.
- There were sufficient numbers of staff available on every shift who had completed advanced paediatric life support training for the children's ward and 98% of staff on the neonatal unit had completed newborn life support training.
- A paediatric staffing review paper had identified the shortage of nursing staffing on the children's ward and recruitment had already started, based on these recommendations. A recruitment programme for the neonatal unit had previously been implemented during 2015, towards meeting national standards for staffing.
- Medicines were stored safely in all ward and department areas, with staff following clear protocols for recording and administering medications.
- Ward areas on children's and neonatal unit, also the children's outpatient department, were visibly clean and orderly, with staff working in accordance with infection control procedures.
- A number of care pathways were in place which followed national guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Child Health and Paediatrics (RCPCH). Specific development had been undertaken which supported young people with diabetes and epilepsy during their transition from children's to adult services

Services for children and young people

- A targeted development in response to outcomes from the National Neonatal Audit Programme had resulted in improved breastfeeding rates.
- We saw many examples of multidisciplinary team working and communications in place with providers of services external to the trust.
- Complaints were at a low level and were mostly about waiting times
- Staff worked hard to deliver the best care they were able to, despite frequent staff shortages. There was a positive culture of staff supporting each other and covering extra shifts to provide nursing care and ensure rotas were filled.
- Staff reported that new leadership had brought some changes and felt more assured that the day to day challenges in paediatrics and neonatal services were now being acknowledged 'from the top'.

Are services for children and young people safe?

Requires improvement

At the last inspection in July 2014 we rated safe as requiring improvement regarding nurse staffing and specific training. At this inspection we rated safe as requires improvement because:

- Nurse staffing levels on the children's ward did not reflect Royal College of Nursing (RCN) standards (August 2013) and the ward was regularly short staffed. Staffing numbers were reported to senior managers on a daily basis.
- Nurse staffing levels on the neonatal unit did not always meet standards recommended by the British Association of Perinatal Medicine (BAPM), with managers advising that they were 80% compliant with these.
- We found there were inconsistent checks of emergency resuscitation equipment and transfer incubators on the neonatal ward. This was reported to the Matron during our inspection and we saw appropriate action had been taken to correct this.
- Paediatric early warning scores were not actioned consistently and we saw some evidence that actions were not recorded when a patient's score changed from amber to red.
- An isolation cubicle was available for patients admitted for Child and Adolescent Mental Health Services but there was difficulty in providing 1:1 nursing supervision for this area, due to staffing demands. Also, there was a potential ligature point in the en-suite bathroom for this room, which was raised to the trust during inspection.
- Access to ward areas on the children's and neonatal unit was controlled by security doors with intercom and camera. However, during our visit one of the inspection team managed to gain access to the ward by following a group of parents onto the ward and was not challenged.
- The physiotherapy gym was at a distance from the main ward area and did not have access to an emergency bell or phone in case of any urgent need.

- We observed that some of the internal staff rooms and offices on the children's ward were noticeably higher in temperature than ward areas. Staff told us that the playroom was unable to be used at times in summer months, due to the temperature being too high.
- On the neonatal unit, the temperature checks for the donor breast milk fridge and the fresh breast milk store had been missed on three occasions in September 2016.
- Staff reported frequent demands in providing for the needs of patients who were admitted for child and adolescent mental health services, highlighting a lack of continuing specialist service support for this area.

However;

- A paediatric staffing review paper completed in June 2016 identifying the shortfall in nursing staff numbers had been approved by the Trust Board. Recruitment of nursing staff had been started, based on recommendations from this staffing review.
- There were sufficient numbers of staff who had been trained in Advanced Paediatric Life Support (APLS) available to cover every shift on the children's ward and 93% of nursing staff on the neonatal unit had completed training in newborn life support. From review of staffing rosters on the children's ward we saw that there was at least one and usually two members of APLS trained staff to provide cover on each shift. This was an improvement from the last inspection.
- Medicines were safely stored on all ward and department areas, with clear protocols and practices in place for checking and dispensing medicines.
- Ward areas were visibly clean and orderly, with staff observing current guidance for infection prevention and control.

Incidents

- Between 1 April 2016 and 1 July 2016, there were 181incidents reported on the children's ward, of which 174 were classified as low or no harm. For the same time period, there were 71 incidents reported on the neonatal unit, of which 50 were classified as no or low harm. Most incidents resulting in low or no harm were related to medication errors and the trust had implemented actions in response to these.
- Between August 2015 and July 2016, there were no never events reported. Never events are very serious, wholly preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.
- Four serious incidents were reported within the children and young people's services between August 2015 and July 2016. A process for rapid review of serious incidents was in place, incorporating root cause analysis and lessons learned from these incidents.
- Two of these serious incidents related to failure to obtain an appropriate bed for a child when it was needed. One related to an unexpected child death within 48 hours and another was under review for a delayed transfer of a child to a specialist children's hospital. We saw evidence that a root cause analysis had been completed with regard to each serious incident and that lessons learned had been identified and shared.
- Incident reporting was made using an electronic reporting system. All incidents and actions were reviewed within 72 hours by the ward manager or senior nurse, as well as the Clinical Governance Lead. The Clinical Governance Risk Manager for children's and neonatal wards was based on the children's ward and was accessible for quick response when this was necessary.
- Staff on the children's ward were able to describe their role and responsibilities in identifying incidents appropriately, giving examples of when they had reported an incident. An example was given of a recent incident which related to parental access for children on the ward, highlighting related safeguarding and potential security issues. This had resulted in the development of a checking procedure and in shared learning for staff.
- The Ward Manger and Clinical Educator communicated update information regarding incidents to all staff, in weekly email bulletins and monthly staff meetings. The clinical educator held monthly lessons learned sessions during these meetings and ward staff confirmed they had received information through this process.
- At the time of the inspection, children and young people's services did not attend the trust's morbidity and mortality review meetings. However, senior clinical staff in paediatrics advised that clinicians did meet regularly to review and discuss child deaths; also these cases were always followed up by the safeguarding

team. We were told of future plans to hold weekly morbidity review meetings, together with quarterly case discussions for all paediatric staff. We saw communications regarding these future developments; however we saw no records of paediatric morbidity and mortality meetings that had been held to date.

- Staff covered duty of candour training in their mandatory training programme, however not all staff were able to describe what this meant in practice. 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. Nursing staff told us that if an error had been made which had affected patient care, a checklist webform was used and documented in patient notes. Doctors would speak to parents to provide follow up information when this had been identified.
- The children's ward reported data to the health and social care information centre in measurement against the NHS Safety Thermometer. The NHS Safety Thermometer is a tool designed to be used once a month by frontline healthcare professions as a snapshot of specific harms. Two pressure ulcers were reported to the NHS safety thermometer between July 2015 and July 2016, with two falls and no Catheter related Urinary Tract Infections reported for the same time period. This information was displayed on notice boards for staff and patients to view.

Cleanliness, infection control and hygiene

- Ward areas in the children's outpatient department, ward and neonatal areas were observed to be visibly clean. Adequate handwashing facilities and gel were available with clear handwashing signs displayed. Staff were observed using personal protective equipment, including aprons and gloves, to minimise the risk of infection and were 'bare below the elbow' in accord with trust infection prevention and control guidelines.
- Isolation bays were available on the children's ward for patients with infection, to reduce the risk of contamination and appropriate protocols were in place for nursing care and management.
- Results of hand hygiene audits were displayed on the ward and these showed 100% compliance. Hand hygiene audits completed in March to June 2016 showed 100% compliance for nursing staff on neonatal and children's ward. There was a lower rate of 88% compliance in May 2016, for doctors on the neonatal unit, however this returned to 100% June.
- There had been one incidence of Methicillin-resistant Staphylococcus Aureus which had been acquired in the community in a patient who had complex needs. There were no cases of Clostridium Difficile between August 2015 and July 2016.
- Health care assistants maintained a register of cleaning tasks for ward areas and these activities were reported and checked daily. General cleaning tasks were completed by housekeeping staff and we saw accurate and up to date records of all tasks that had been completed. Equipment that had been cleaned was labelled to identify this and all labels we inspected were in date.
- Hospital play specialists ensured all toys were cleaned before and after each patient use, in addition toys were fully cleaned each week. Up to date records confirmed these checks had been completed
- On the neonatal unit, a performance board displayed information about the focus of the month. Included in this for the month of September 2016 was a focus on handwashing, neonatal sepsis rates data and 'prevail-prevent infection'. This related to a research programme into the use of longline antibiotics for treating babies.

Environment and equipment

- Access to ward areas on the children's and neonatal unit was controlled by security doors with intercom and camera. The children's Ward Manager told us there had been a push for tighter security following three incidents where patients admitted for child and adolescent mental health services had absconded. We were informed that parents who were with children on the ward were asked to be vigilant about possible 'tailgating' at ward doors by individual patients exiting, or members of the public trying to enter. However, during our visit one of the inspection team managed to gain access to the ward by following a group of parents onto the ward in this manner and was not challenged.
- Emergency equipment for resuscitation was located in accessible positions on the children's inpatient and outpatient areas. Trolleys were secured with security tags. Equipment and medication checklists were signed and records completed at least daily. However, one

record was ticked but not signed for on the children's ward emergency trolley for the week prior to our inspection. All equipment items and emergency drugs on the trolley were checked and observed to be in date.

- We found that checks of emergency resuscitation equipment were not completed consistently on the neonatal unit. Signed checklists for the emergency box in the special care baby unit were not completed on two days out of seven in the week prior to our inspection visit. Checks on the internal transport incubator were incomplete for two days in the previous month and records of checks on the external transport incubator had not been completed consistently on a daily basis during August 2016. We raised this to the Matron who advised that the external transport incubator had not routinely been checked on a daily basis, but this was only done during the periods when the neonatal ward provided cover for the northwest neonatal operational delivery network. As a result of identifying this issue, we saw that new systems for daily checking of the internal and external transport incubators were being implemented.
- Medical equipment on ward and in patient areas was labelled and safety checked. In the equipment store room on the children's ward, items that had been noted as without a next service due date had been separated for review by the medical engineering department. During our visit, we observed the medical engineer completing checks on this equipment and confirming that the service history was complete for the equipment. We saw records which confirmed this.
- The paediatric physiotherapy gym had no telephone or call alarm and therapists said it was not safe for use if they were working alone, due to its distance from the ward. This was escalated to senior managers at the time of inspection; however no further update was available regarding this during our on-site visit.
- The children's outpatient area was separate from the main hospital outpatient department, with automatic doors controlled by a push button from an external entrance. The doors had a safety mechanism that would close the doors from the inside in order to prevent toddlers and children trying to exit. Warning notices were in place to advice of safety needed due to the busy road outside the entrance.
- A link corridor from the main hospital entrance also provided access to the children's outpatient department, through an internal door at the back of the unit. Although this door was locked by a cleaner in the evenings, it was not keypad controlled and there could be times when the door remained unlocked after the department had closed. This could mean that members of the public could access the department out of hours when it was unsupervised, presenting a possible security risk.
- There was a large and well-lit play room for children's use on the ward. However, during summer months this became unsafe to use when the temperature was hot. An air conditioning unit had been supplied which had also failed, resulting in interrupted use of this facility for short periods of time.
- An office room used by doctors on the children's ward for administrative work was reported as having difficult working conditions, being frequently too hot due to computers in the room. We observed that some of the internal staff rooms and offices on the children's ward were noticeably higher in temperature than ward areas.

Medicines

- Medicines were stored securely in locked rooms on the wards and outpatient areas. Medicines stored on the ward and outpatient areas were inspected and noted to be within date.
- Controlled drugs were stored in a separate lockable cupboard within the medicines room on the children's ward and outpatient areas. We saw there were safe systems in place for management of controlled drugs.
- Fridges used on the wards for medicines storage had secure locks in place and daily temperature records were logged in a record form. Fridge temperature ranges were recorded and dated daily on the children's ward.
- On the neonatal unit, the temperature checks for the donor breast milk fridge and the fresh breast milk store had been missed on three occasions in September 2016.
- An efficient reporting process was in place specifically regarding medication incidents. This used a matrix which identified relevant actions to take related to different levels of medication error. During our visit we observed this having been appropriately applied and noted in case records.
- A sample of prescription charts were reviewed on the neonatal and children's wards and these records were signed, accurate, dated and legible. There was evidence that prescription charts had also been reviewed by a pharmacist

- We observed medicines being given to a child on the children's ward in accordance with the prescription detail. Two nurses were observed to check the prescription and dose and the child's name band and details were checked before the medicine was administered.
- We heard from one parent about how an antibiotic dose had been missed for their child post- operatively, but that this had been picked up by a nurse on the night shift who discussed the issue with a doctor for corrective advice.

Records

- We reviewed 12 sets of records on the children's ward and five sets on the neonatal unit. The children's records all indicated they had been seen by a consultant within 12 hours of admission and they had a care plan which was reviewed and documented in the notes.
- Individual patient demographic information (name, address, date of birth) was consistent and correct throughout the records inspected. The individual person who held parental responsibility and was able to consent for the child's treatment was documented in care records.
- All records were signed and dated with the name of the doctor clearly documented. Patient records were kept in a secure trolley on the children's ward and neonatal units.
- We looked at the intensive care plans for babies on the neonatal unit and these were clearly recorded, signed and dated. All neonatal care plans gave detailed prompts and precise instructions which follow national guidelines for neonatal care. The care plans also included reference to an intensive care booklet and a special care booklet held on the unit, which provided further in-depth guidance for staff to follow.
- In the children's outpatient area we saw that some children's case notes were left on open shelving in the administrative area. Staff informed us these were left out overnight in preparation for clinic appointments the following day. We noted there was potential for public access through an internal back door to the children's outpatient area, particularly when the department was unsupervised out of hours. This could mean that sensitive personal information in children's case notes was not securely protected. We raised this issue with the department manager and the trust during our on-site visit.

Safeguarding

- There were two designated safeguarding lead nurse roles for the child health division, covering the children's ward, outpatients department and neonatal units; also a safeguarding lead doctor was identified. Staff on neonatal units also had access to safeguarding advice and support from the designated safeguarding midwife leads in maternity services.
- Safeguarding examinations were completed in the children's outpatient department by the named consultant. When safeguarding examinations were required during out of hours, these would be completed by the designated registrar (doctor) on the children's ward.
- Staff reported that any initial safeguarding concerns would be raised and discussed with senior staff for further advice, or raised directly to the safeguarding lead nurse for children and trust safeguarding team. Staff were aware of the trust safeguarding policy and described examples of how they had raised safeguarding concerns and followed procedures appropriately. The safeguarding team conducted regular audits of safeguarding referrals and this information was shared with the ward based Risk Manager and ward staff.
- On the paediatric assessment unit (PAU), we were told that parents may leave with their child against medical advice, due to waiting times. We observed there was a clear process for follow up where this had happened, involving contact with the child's parents, Health Visitor or School Nurse. If staff had any further safeguarding concerns, an incident report would also be logged by staff.
- In the children's outpatient department, additional safeguarding measures were in place to flag occasions where a child had failed to attend an appointment. Here, a paediatric date stamp would be attached to the child's case notes for the consultant to assess for any further action required, including referral for safeguarding.
- On the children's ward there was a separate cubicle for patients admitted for Child and Adolescent Mental Health Services (CAMHS). This cubicle was frequently used for children and young people who displayed challenging or aggressive behaviour. However staff told us that it was not always possible to provide one to one

supervision for this area due to staffing demands. We were told that most of the children and young people who were admitted with self-harming behaviour were nursed in bays on the main ward.

- During inspection, we requested a risk assessment for the CAMHS isolation room and we saw this had been completed but not dated. This assessment detailed the measures in place to reduce the risk to patients where the potential for further self-harm had been identified. These measures identified that shatter proof glass was in place in windows and mirrors. However, a potential ligature point on an emergency pull cord was seen in the en-suite facilities, which was reported to the trust during the onsite visit. •Safeguarding training was mandatory for all staff, with different levels of training provided at level one, two or three, dependent on role. Safeguarding training was provided as part of mandatory training, as well as E-learning and classroom training for level two and three safeguarding. Trust data indicated that 68% of staff had completed level two child protection training, which was worse than the trust target of 90%. However, we reviewed locally updated records of staff training held at ward level during the time of inspection which were inconsistent with trust reports regarding training. These showed that all paediatric staff had completed level two safeguarding training previously but 21 staff were out of date for their annual update. This was equivalent to 85% against the trust target of 90%. All of these staff were booked onto forthcoming training sessions in the coming two to six weeks.
- We received different feedback from nursing and other staff working in direct regular contact with children regarding their level of safeguarding training. Many of these staff stated they had completed safeguarding level two training only. This did not meet the required standards referenced in the March 2014 Intercollegiate guidance document - Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. This guidance states that all clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to level three in safeguarding as a minimum requirement. However the trust grading of safeguarding training was different to the intercollegiate grading and level 2 at the trust equated to level 3 intercollegiate.
- We reviewed local records of safeguarding training for neonatal staff, kept by the Clinical Educator on the neonatal unit. These showed that 54% of qualified band 5 nursing staff had completed level two safeguarding training and 64% of qualified band 6 nursing staff had completed level three safeguarding training. Safeguarding child protection training as part of mandatory training was completed by 90% of staff.
- Training in female genital mutilation was provided as part of level three adult safeguarding training, which was not currently accessed by neonatal staff, however this subject was covered in sessions provided by colleagues in maternity services.

Mandatory training

- Some of the core subjects included for mandatory training were fire safety, resuscitation, information governance and manual handling. In addition, the trust had varying targets for the percentage of staff that needed to be compliant (up to date) with other specific training, dependent on staff role.
- The training figures for the child health division were included in the overall training report for the medical division at 1 May 2016. These figures indicated that 77.7% of nursing and midwifery registered (qualified) staff had completed their mandatory training, this was slightly worse than the trust target of 80% compliance.
- However, we saw training records held at local ward level showing that at the time of our on-site inspection, 64 out of 75 staff across the child health division had completed their mandatory training. This indicated an overall compliance rate of 85%, above the trust target of 80%. There were six members of nursing staff included in this staff total who had not completed their mandatory training. We saw evidence of planned attendance for these staff to complete their mandatory training in future sessions being held in the weeks following our inspection.

Assessing and responding to patient risk

- The trust used Paediatric Early Warning Scores (PEWS) to monitor the condition of children who were unwell. The PEWS is a standardised tool that measures the child or infant's clinical status and recommends an appropriate response, if a child's condition changes. The

indicators used for PEWS were based on a red-amber-green system of scoring. One hundred percent of nursing staff on the children's ward had completed PEWS training.

- Staff informed us that PEWS included actions to escalate where a child's condition deteriorates. During inspection on the children's ward we noted in three PEWS records, amber scores had not been repeated when they should have been. In one case there was separate documentation that the child's parent did not want to wait to be reviewed by the doctor. Staff were unable to demonstrate actions required for red and amber scores in these cases.
- We were told that the PEWS charts had not been in use long and that these were under review by the Ward Manager and Clinical Educator, with future plans to audit triage assessment time and use of PEWS. We observed that a copy of PEWS actions was displayed on the day case ward.
- On the children's ward, senior staff including the Ward Manager, Clinical Educator and all six ward co-ordinators had completed Advanced Paediatric Life Support (APLS) or equivalent European Paediatric Advanced Life Support (EPALS) training. Other qualified nursing staff completed Paediatric Immediate Life Support (PILS), although two staff were not currently up to date with this due to sessions being cancelled by the resuscitation training team. The Clinical Educator was implementing extra ward based sessions to cover this training need and we saw that staff were booked to complete these update sessions where required. Other staff on the ward and in children's outpatients completed training in Paediatric Basic Life Support (PBLS) skills.
- We reviewed staff rotas on the children's ward to confirm that ward shifts were covered by at least one nurse and usually two members of nursing staff who had completed APLS.
- On the neonatal unit, 93% of staff had completed Newborn Life Support (NLS) training. Nursing staff on the neonatal unit used observation and professional judgement to monitor the condition of babies on the ward.
- The neonatal unit provided cover for nurse-led support on an alternate weekly rota basis to the Lancashire and South Cumbria regions of the North-West Neonatal Transfer Service. This team provided specialist transport services for babies who required intensive, high dependency or specialist care during transfer between regional specialist neonatal units and hospitals.
- Patients who were admitted to the children's ward requiring Child and Adolescent Mental Health Services (CAMHS) would be seen for assessment the following working day. However, there was no ongoing specialist service provision to support the needs of these children and young people during their inpatient stay. We heard repeated comments from nursing staff at all levels that this situation presented extra demand on staff on a regular basis. For example, CAMHS patients often required nursing care from three nurses to one patient; nurses observed that often risk taking behaviours were increased for CAMHS patients whilst they were on the ward. There had been no additional training support for nursing staff, although meetings had been held with local mental health services to discuss the issues raised.

Nursing staffing

- Nurse managers were working to increase the numbers of qualified and non-qualified nursing staff for the children's ward, in line with national guidance from the Royal College of Nursing (RCN). A paediatric ward staffing review paper had been submitted to the trust executive board in June 2016, which had identified staffing shortfalls in paediatric nursing numbers. This paper identified that current staffing establishment on the children's ward was below what was required to sustain a safe and effective service to paediatric patients and their families.
- The whole time equivalent of nursing staff for the children's ward was 64.68. The proposed number of staff identified for the first phase of development was 86.83. Recommendations had been proposed for increasing the staffing numbers, with initial recruitment of nursing staff already started. One band 5 nurse had started in April 2016; three were starting in October and one in November. We were told by senior staff in the department that a final decision from the executive board regarding approval of the full staffing review proposals was anticipated in October 2016.
- In day to day practice on the ward, shift rotas indicated that there was an average number of nine qualified nurses plus two health care assistants to cover all ward areas during the day, this reduced to eight qualified nurses on the night shift. Depending on patient care

needs, this meant that trained nursing staff worked to a ratio of between 1:4 and 1:8 nurses to patients. RCN guidance recommends a staff ratio of 1:3 for children under two years and 1:4 for children two years and above, with 1:2 for High Dependency Unit (HDU) nursing care. Staff told us that average workloads were one nurse for every six patients. Staff felt that staffing levels had improved over recent months and staff felt more reassured since the staffing paper had been submitted, however we also heard staff report that prior to this, average staff to patient ratios were much higher as a general rule. We were told of an occasion where there was a staffing ratio of 1:12 patients.

- We were also told that 12 members of staff had left during the past year, some in response to the work pressures on the children's ward. Staff commented that they had too many patients to care for on the ward, with many staff saying that last winter was exceptionally difficult. On one occasion, staff said there had been seven patients on the ward with high dependency needs, whilst the ward only provided two high dependency beds. We heard nurses say that there was not enough time even to speak to patients and they only had time to do the bare minimum, which parents got upset about. We requested data from the trust to confirm this detail; however the data provided was not in a suitable format to enable us to corroborate this information.
- There were 30 incidents reported between April and June 2016, with regard to staffing levels on the children's ward.
- Daily decisions about nurse staffing on the children's ward were made according to professional judgement and assessment of clinical needs. There was no acuity tool in place to determine the appropriate levels of nurse staffing in response to the varying care needs of patients. Nursing staff were deployed between the different ward areas according to levels of patient care needs, including cover for the HDU beds and ward, the PAU and day case areas. Staff were allocated to ensure there was a senior member of staff working to support junior nurses in the different ward areas. The Ward Manager and Clinical Educator were not included in the daily staffing rota numbers but, when required, they would work on the ward to provide cover.
- The children's ward and neonatal units would cover any shortfall in staffing by staff working extra shifts or longer hours. Staff rotas on the children's ward showed that nursing staff were routinely doing extra shifts once or twice a week. Additional cover was sometimes provided by bank staff but there was limited use of agency staff, with a limited availability of suitably qualified agency staff available.
- A revised escalation policy had been drafted to replace the previous version, which was described as vague. This new escalation policy identified clear triggers to determine action to take when the staffing levels were not at a safe level for the ward areas, identifying a nursing ratio of 1:6 as a red flag. On the days of our on-site visit there were no patient admissions for HDU beds, however we saw that the new escalation policy had been implemented on the day previous to our unannounced inspection, when the ward had reached capacity for admissions. This had resulted in the ward being temporarily closed to admissions until patient needs and staffing levels returned to safe levels.
- During 2015, there had been a recruitment drive for neonatal staff. Managers informed us that staffing levels had improved and the unit was now 80% compliant with standards of staffing recommended by the British Association of Perinatal Medicine (BAPM). The guidance for staffing recommends a staff ratio of 1:1 for Paediatric Intensive Care Unit and 1:2 for High Dependency Unit
- During our inspection we saw that the neonatal unit was very busy. The staff rota for one day indicated 12 nursing staff were rostered, however only 10 were on duty, with no health care assistants or nursery nurses working to provide extra cover. The consultant had been made aware, however this had not been escalated to senior managers on this occasion. The staff rota for the next day indicated insufficient numbers of staff for the unit, with only 10 staff rostered for Saturday shifts and nine for the evening. We raised this to the trust during our onsite inspection. Information provided by the trust showed variation in compliance with the BAPM standards with 14 of 30 days in September 2016 being less than 95% compliant.
- Staffing levels on the children's ward and neonatal units were reported daily to senior managers. There was executive support for any decision to close the ward to admissions when this was indicated, through appropriate application of the escalation policy •Some staff on the children's ward said they had often reported staffing shortage as an incident and we saw that there had been 30 incidents reported regarding staffing between April to June 2016. Of these, 25 were directly

reporting unsafe levels of staffing, with other incidents relating to delays in medications being administered due to insufficient staffing. Other staff informed us that incidents were not always recorded regarding short staffing, due to their being too busy on the shift at the time. We heard from staff that there was a good approach to incident reporting and this was not looked at negatively or with blame; managers were reported to be supportive.

- Safety huddles were held on the children's ward and neonatal unit several times throughout the day for staff to share updates regarding the condition of patients. A nursing handover was observed, in which confidential details and safeguarding issues regarding patients were first discussed in the Ward Manager's office, followed by one to one nursing handover at each individual patient's bedside.
- The neonatal unit communicated with the central cot bureau at St Mary's NICU, Manchester throughout the day to update cot occupancy status to facilitate flow of patients through the system. This was an independent system to the one used by the Trust.
- Staff worked hard to ensure patients received the best care, despite frequent shortages of staff on the ward. Staff frequently worked longer hours and additional shifts in order to ensure safe care was provided and nurses were committed to delivering a caring service for children. Staff said they would "go above and beyond" to keep standards of care for patients in order to "deliver the best service with the means they have got".
- The annualised sickness rate for qualified nursing within paediatrics was 2.75%, from August 2015 to July 2016, which was better than the overall trust staff sickness rates of over 5%.

Medical staffing

- The percentage of consultants working in paediatrics within the trust was 42%, which was better than the England average of 40%. For middle career doctors the percentage was 8%, which was better than the England average of 7%. For junior grade doctors the percentage was 8%, again better than the England average of 7%.
- The percentage of registrars working in paediatrics within the trust was 42%, which was worse than the England average of 47%.
- Each consultant had a one in six duty as consultant of the week, covering all acute admissions and safeguarding cases. Two paediatric consultant neurologists were based at Royal Preston Hospital providing outreach cover for the whole of Lancashire, but who did not participate in the out of hours rota for emergency cover.
- Senior clinical staff informed us of plans to increase the number of consultant paediatricians to meet compliance with "Facing the Future" standards, proposed by the Royal College of Paediatrics and Child Health. There are eight consultants at the time of our inspection, with planned recruitment to establish ten consultants over the following nine months
- Senior clinical staff advised that six out of seven sessions were filled on the rota and that locum staff were used to cover any shortfall, with one of these being a regular locum.
- One Assistant Nurse Practitioner (APNP) and a trainee APNP worked on the PAU and this assisted in day to day cover. Two further staff had been accepted to start their APNP training and were expected to complete this during the 12-18 months after our inspection.
- We observed a medical handover on the children's ward in which a handover sheet was circulated to medical staff. This provided summary details regarding the child's age and date of admission, as well as pertinent information regarding the child's medical condition and recommendations for care. There was a handover for each patient given by the night registrar, with appropriate intervention from the paediatrician when required. The handover included referrals to the outreach team by the paediatrician also discussion regarding a child's safeguarding referral was shared.

Major incident awareness and training

- The trust had a major incident policy which staff were aware of and a copy of the major incident file was kept in the ward office which staff could locate readily. Staff could describe how they would be deployed to priority areas in an emergency.
- Major incident awareness and training was covered as part of the trust's mandatory training programme.

Services for children and young people

Are services for children and young people effective?

Good

At the last inspection in July 2014 we rated effective as good. At this inspection we rated effective as good because:

- The children's ward and neonatal units followed guidelines from the National Institute for Health and Care Excellence and there were a number of evidence based care pathways in place.
- Services participated in national audit programmes including the National Neonatal Audit Programme and the National Paediatric Diabetes Audit and were able to identify improvement plans from these outcomes.
- Development of transition pathways for children who had epilepsy and diabetes when moving from children's to adult services had been progressed, through a successful funding application to NHS Advancing Quality projects.
- The children's unit used age dependent pain assessment tools and parents felt their child's pain was well controlled.
- There was good multi-disciplinary working with local therapy services, the children's outreach team and specialist children's hospitals. A specialist service for children with neuromuscular conditions was provided across Lancashire and South Cumbria.
- Records we reviewed showed clear documentation of the individual who held parental responsibility and who could provide consent for the child.
- The national audit targets for paediatric diabetes were being achieved 2014-2015.

However;

- The rate for multiple admissions due to asthma and diabetes and the rates for emergency readmission within 24 hours after discharge were higher than the England average during March 2015 to April 2016
- Physiotherapy services were not using competency tools and staff working in general physiotherapy lacked confidence in specialist paediatric techniques. The trust identified immediate plans in response to this finding during our inspection.
- Out of 37 guidelines for the neonatal unit, only three were currently in date.
- Some junior nurses on the children's ward reported that they had not fully completed their nursing preceptorship and that they felt unsupported to work in high dependency areas of the ward.

Evidence-based care and treatment

- A ward based Clinical Educator worked closely with consultant paediatricians to ensure that local care pathways reflected current best practice guidelines from the National Institute of Health and Care Excellence and the Royal College of Paediatric Child Health. We observed a number of care pathways in place, including for example, for diabetes, asthma and epilepsy.
- A new sepsis pathway was being developed in response to revised national guidance and the ward participated in the trust's continuing quality developments for the management of sepsis.
- Documentation for day case surgery reflected the World Health Organisation's checklist for safer surgery. An integrated care pathway for paediatric day case surgery under general anaesthetic had been completed in January 2016 and this was in the process of being implemented.
- Staff described how they met regularly to review their progress in the national paediatric diabetes audit, including development of a new policy. This had assisted towards improving outcomes in the national audit and there were ongoing action plans to address this.
- Development of transition pathways in epilepsy and diabetes had been implemented through successful funding application to a two year NHS Advancing Quality Alliance project. This work supported care planning for young people with epilepsy and diabetes, when moving from children's into adult services.
- Protocols were in place for medical investigations and procedures, with some staff having completed additional training, including for example in IV cannulation and catheterisation procedures.
- The children's ward had introduced an under two year old falls assessment in response to a recent rise in incidents of falls, noted in data reports to the NHS Safety Thermometer. Staff were able to locate the assessment form, however we did not see any of these completed during our inspection.

- Hospital play specialists saw all patients to offer developmental play and participated in a Northwest regional network for benchmarking services and sharing best practice. Children with long-term or complex needs were provided with a play programme, which was completed by play leaders or student play specialists.
- The children's ward met monthly and worked closely with regional specialist centres for children and young adults with cancer, in order to support delivery of care for these patients on the ward.
- Staff in physiotherapy services provided cover for the children's ward and neonatal unit, but there was no use of competency tools for prioritising treatment. Paediatric physiotherapy staff reported that 60% of their time was spent on training other general physiotherapists in respiratory techniques. However, it was reported that many of these staff still lacked confidence in being able to deliver paediatric physiotherapy services
- Speech and language therapists provided cover for the children's ward and neonatal unit and were involved in a national neonatal group as part of the Royal College of Speech and Language Therapists. One speech and language therapist was currently completing a Master of Arts qualification and had completed an audit of waiting times for video fluoroscopy services as part of this. Video fluoroscopy is an X-ray procedure used to assess swallowing difficulties.
- Research nurses based on the neonatal ward were involved in two research programmes, related to neonatal feeding and antibiotic long line treatments.
- A total of 37 guidelines were in place for the neonatal unit, however only three of these were in date and no current guidelines were on the trust intranet. Managers told us this was due to administrative issues and that these guidelines had been reviewed and were current. The Ward Matron described how neonatal care plans were extremely detailed with clear prompts, in order to reflect national guidelines. We reviewed a number of neonatal care plans and saw these provided clear directions and prompts as described.

Pain relief

- The children's unit used age dependent pain assessment tools. For younger children a smiley faces pain rating scale was used and for older children a numbered pain ladder score was used.
- Analgesia and topical anaesthetics were available to children when they needed them in the children's ward and outpatient areas.
- Parents we spoke with thought their child's pain was well managed. However, one parent reported their child had been sent home with unresolved pain on a recent attendance to PAU, when the child had described their pain level at ten. The subsequent attendance to PAU had resulted in their child having surgery.

Nutrition and hydration

- Patients in PAU were offered food and drink whilst they were waiting and there was a vending machine in the area for families to use. Staff provided a tray of sandwiches for patients in the waiting area.
- Food on the children's ward was described as looking and smelling good. There was a menu choice with sandwich options available.
- On the neonatal unit, two neonatal nurses provided support for breastfeeding to mothers. The ward was working towards baby friendly accreditation and had an action plan to improve uptake of breastfeeding.

Patient outcomes

- Data findings indicated that children's ward emergency readmission rate (within two days of discharge) was worse than the England average between March 2015 and February 2016. However, senior clinical staff, they felt this was possibly due to the 48 hour open access contact offered to parents after discharge. Any contact made with children and parents during this period and the coding recorded for this contact would reflect incorrectly in this data as a new admission. Senior clinical staff were going to investigate this issue further.
- The children's unit participated in the national paediatric diabetes and asthma audit programmes, however data showed that multiple readmission rates for asthma and diabetes were worse than the England average between April 2015 and March 2016. Also, performance was worse than the national average in the 2014/15 paediatric diabetes audit programme. We saw evidence of action plans to improve these outcomes.
- Comparison of the 2014 and 2015 results in the National Neonatal Audit Programme showed improvement in two of the seven areas; maintained performance in two areas and a reduced performance in the giving of antenatal steroids from 89 to 82% and in the breastfeeding at discharge which had fallen from 46

to 33%. Actions had been implemented to improve this and senior clinical staff advised there had been improvements in uptake of breastfeeding, as well as neonatal temperature recording within four hours of birth. We saw documented evidence of temperature recording in all neonatal case notes reviewed.

Competent staff

- Data provided by the trust indicated that 88% of paediatric staff had completed their staff appraisals, with the trust target being 90%. All new nursing staff completed an 'aspirational meeting', with newly qualified nurses receiving preceptorship training from senior nursing staff, for between six and twelve months. All staff held a record file of learning and development as evidence towards their nursing revalidation.
- Nurse managers on the children's ward and neonatal unit advised that appraisals for nursing staff were currently up to date, however the overall appraisal rate for staff in child health was still below the trust target of 90%.
- Staff said that in day to day practice, there tended to be more informal clinical supervision and reflective discussion in handovers between ward coordinators and junior staff. There were no formal records available to assess regarding this.
- Band 3 Health Care Assistants (HCAs) provided supervision to band 2 staff and completed a preceptorship programme, similar to student nurses. Senior nursing staff signed off HCAs for their competencies in clinical and other tasks. HCAs we spoke with felt there was good support from trained staff and they received regular updates from the Ward Manager and Matron by email and in staff meetings.
- Ward-based training sessions were held once a month by the Clinical Educator and during our visit we saw one of these in progress for high dependency care training. Attendance at these was however a challenge, due to working pressures on the children's ward.
- Some nurses on the children's ward told us they had been qualified only a few years and had received good preceptorship from a mentor initially, but were relied on too much. One told of having been rostered as supernumery during an induction period of two weeks, but was then left on the ward to work alone. We heard one comment that it felt like being a jack of all trades and master of none.
- Another junior nurse told us they felt unprepared for working in the high dependency area of the ward, having three patients to care for on the first occasion. The shift was very busy and they did not feel supported. Senior staff were approachable for queries to be raised, but not always available. We saw evidence that staff completed training for High Dependency Unit (HDU) competencies, which was overseen by the Clinical Educator.
- Appraisal records for all medical staff were up to date in children's and neonatal areas.

Multidisciplinary working

- Senior clinical staff reported there was good team working on the children's unit and that a range of specialist support was available from physiotherapy, speech and language therapy and dietetics services.
- There were communications in place between the ward and regional specialist children's hospitals. These provided specialist support for children with conditions such as Cystic Fibrosis, Cardiac, Renal and Neurological conditions.
- Referrals could be made to the children's nursing outreach team directly by paediatricians on the ward or clinic. The service accepted referrals for nocturnal enuresis in children age under seven years, to which GPs could refer directly also. The children's outreach team reported there were good working relationships with paediatricians and they were always available for telephone advice if this was required.
- The children's outreach nursing team also worked closely with adult nursing teams, for example joint clinics for epilepsy were held with adult nursing services for epilepsy. There were good communications between the children's outreach nursing team and social care services, with social workers attending Team around the Family meetings for children on the ward when this was required. However, there were no direct links between the children's outreach team and the community children's nursing team.
- A hospital play service provided cover for the ward, day case area and children's outpatient department. This service would see all patients to offer developmental play therapy. Children with long term or complex needs had a play programme, completed by play leaders or students. This service offered student placements, accommodating usually one or two nursery nurses or play specialist students from local colleges.

Services for children and young people

- The patient experience advisor liaised with community carers where a child admitted with complex needs was receiving a package of care at home, including liaison with local children's hospice services to support provision of respite care for families, where this need had arisen.
- A specialist nurse for children with neuromuscular conditions, such as Duchenne Muscular Dystrophy, worked with consultant paediatric neurologists, liaising with physiotherapy, occupational therapy and psychology services. This specialist neuromuscular service provided cover for children across Lancashire and South Cumbria.
- The paediatric diabetes service held transitional clinics on site at Chorley and Preston hospitals, for children moving from children's services to adult services. Transition preparation began from age 13 years, following a red/ amber/ green 'Ready, Steady, Go' process. However, staff reported there was a lack of specialist input from psychology services for the paediatric diabetes service.
- The patient experience advisor worked on the neonatal ward to support families regarding housing issues, linking with social care services and support workers from children's centres. This was because there were many families who were living in deprived areas who accessed specialist care from the neonatal unit.
- A regional monthly cleft lip and palate network clinic was held at Royal Preston Hospital, where newborn babies born with cleft lip and palate on the neonatal unit were referred and seen. Specialist nurses attended this clinic for follow up support.
- A tongue tie clinic was held in children's outpatients for infants with the congenital condition tongue tie. This was supported by a multi-agency team, including speech and language therapist and dietician.

Seven-day services

- Paediatric consultants were on call overnight and at weekends for inpatient ward areas. The children's outpatient department offered appointments Monday to Friday.
- Out of hours provision was available for physiotherapy and pharmacy services.
- The children's outreach nursing team provided weekday services only, with children needing to come back to the ward again over the weekend after they had been discharged, in order to continue some treatments, for example intravenous therapy.Access to information
- Trust policies and procedures were available for staff to access through the trust's intranet and staff could demonstrate where to find these.
- The outpatients department had access to case records in time for children's clinic appointments. Staff reported there were no issues with information being available in a timely way for children's care and treatment.
- We observed that letters to GPs were completed as part of the discharge process on the children's and neonatal wards, with a copy provided to parents. This helped to ensure the child's continuity of care in the community following discharge.Consent
- We observed clear documentation in children's case records of the individual who had parental responsibility and could provide consent for the child. We saw consent records signed by parents who held responsibility for the child.
- In one case we saw how an older child was offered the opportunity to sign for their own individual consent, in addition to the parental consent that had been given.
- Staff were aware of Gillick competence in relation to children under age 16 being able to provide consent for their medical treatment. We saw nursing staff communicating with children in age appropriate ways, offering choice and the ability to consent or decline care procedures, where this was relevant.

Are services for children and young people caring?

Good

At the last inspection in July 2014 we rated caring as good. At this inspection we rated caring as good because:

- Nursing staff treated children with kindness and reassurance when they were being looked after on the ward and neonatal unit and parents generally reported positive experiences of being looked after.
- When children were being discharged, 48 hour access to the ward for advice and support was available in case parents had any ongoing concerns.

- Medical and nursing staff on the neonatal and children's ward were available to provide additional information and emotional support for parents when this was needed.
- A family support worker was available on the neonatal unit to provide additional care for parents, particularly for parents after the loss of their baby.

However;

- The trust performed worse than other trusts for two questions in the 2014 Children Survey relating to communication of information about procedures to patients during their stay.
- We heard from some parents that staff could be abrupt with them, particularly in busy ward areas. Staff on children's ward reported that sometimes it was difficult to find the time they would like to spend with families, especially when the ward was busy.
- The trust did not collect NHS Friends and Family Test data.

Compassionate care

- NHS Friends and Family Test data was not collected on the Children's Ward.
- The trust performed worse than other trusts for two questions in the 2014 Children Survey relating to communication of information about procedures to patients during their stay. Other answers were in line with average responses when compared with other similar trusts.
- During our inspection we observed that nursing staff treated children with kindness and reassurance when they were being looked after on the children's ward, outpatient department and neonatal unit.
- Parents said staff respected their privacy and dignity. When staff and doctors came to speak with children and those close to them in cubicles, curtains were drawn to provide privacy.
- One parent said they had attended the children's outpatients department with each of their four children on separate occasions and had always experienced positive care.
- After children were discharged from the paediatric assessment unit, parents were offered 48 hour open access and telephone contact for follow-up in case of any concern.
- Parents told us staff were helpful, although some staff could be abrupt in communication when it was busy on the paediatric assessment unit.
- There were strict visiting hours on the neonatal unit to allow mothers and babies maximum opportunity for quietness and recovery. Where babies were deteriorating and a decision was being made to withdraw treatment, a side room was provided for parents to be together with their baby privately. Muslim babies had a sign outside their door which said 'whisper' to respect their parents' cultural preference.
- On the neonatal unit, staff told us they took parents to a private area on the ward in order to listen to and document their concerns. One staff member said that once parents felt they had been listened to and their concerns were noted, of the time they felt better 95% of the time. Any continuing concerns will be escalated to the matron who will follow up with parents.

Understanding and involvement of patients and those close to them

- Staff on the assessment unit informed parents of care plans for children and answered their questions about their child's treatment and care.
- Staff on the children's ward and neonatal unit communicated well with patients and families, and parents said they had been shown facilities and given information about the ward.
- We heard from one young person about how staff had involved and supported them in their decision about having a surgical procedure.
- The trust did not complete Voice of the Child audits.

Emotional support

- Staff on the neonatal unit and children's wards provided emotional support for children and families and ensured they had all the information they needed. Doctors were available on the ward to offer further advice when this was required.
- Play specialists were based on the ward and provided care in the outpatients department, supporting children's pre-assessment clinics, also providing diversional activities and accompanying children undergoing anaesthetic procedures when having surgery.
- A patient experience advisor provided additional support to all parents and carers on children's and neonatal wards, Monday to Friday. The advisor attended

daily ward handovers and spent time with parents, providing information about how the ward worked and whether any respite or other general support was required. If a parent had any particular anxieties regarding their child's illness and admission experience, the advisor would liaise with staff for further response to this.

- Children admitted to the children's ward who needed Child and Adolescent Mental Health Services (CAMHS) were supported by ward staff, however there was no registered mental health nurse on the ward to provide ongoing specialist advice for these patients.
- Staff took time to offer holistic family-centred care for children on the ward who had complex needs. However, we heard from a number of staff that it was sometimes difficult to find enough time to spend with families, especially when the ward was busy.
- On the neonatal unit, a family support worker was available four days a week to offer parents support, particularly for parents following the death of their baby. The hospital held annual remembrance services for families who had lost babies or children
- Neonatal staff and midwives received emotional support and time for a debriefing, provided by a team leader who specialised in bereavement aftercare. A hospital chaplain was also a trained counsellor and offered staff further support where needed.

Are services for children and young people responsive?

Good

At the last inspection in July 2014 we rated responsive as good. At this inspection we rated responsive as good because:

- The children's ward and out-patient areas provided child-friendly environments with suitable activities and toys appropriate for different age groups. A sensory room was available on the ward for children, with specialist equipment, particularly suitable for children with complex needs.
- Parents were encouraged to stay with children on the ward and there were facilities for parents to make drinks and have snacks. Support was available towards travel costs and accommodation was provided free on the hospital site for parents of babies on the neonatal unit.
- Interpreter services were available where needed and information was provided for parents if they wished to raise a concern or make a complaint.
- Data from the trust showed that the waiting time for referral to treatment was within the national 18-week target. We saw evidence of learning from complaints and improvement actions in response to these.

However;

- The children's community nursing team which provided support at home for some children after their discharge from the ward did not provide a seven day service. This meant that some children needed to come back to the ward at weekends following discharge in order to continue their treatment.
- There were delays in accessing specialist beds in Child and Adolescent Mental Health Services, as well as delays in discharge for children with complex needs awaiting community packages of care.
- The paediatric assessment unit was a particularly busy ward area and most complaints were about waiting times here.

Service planning and delivery to meet the needs of local people

- The children's ward was light and decorated with child-friendly images. There were plenty of toys available for different age groups and there was a separate large playroom on the ward. Hospital play specialists ran a daily play activity here between 2.30pm and 3pm to offer parents respite, although some days this had to be cancelled, depending on staffing.
- The play service saw all patients to offer developmental play. Children with long-term or complex needs had a play programme, which was completed by play leaders or student play specialists.
- There was a multi-sensory room for use by children and families on the ward, with a variety of specialist toys, audio and visual equipment.
- Children staying on the ward had access to a schools service during their in-patient stay.
- There was a separate room for teenagers to use on the ward, with a door and a window. This ensured that

teenagers had access to a private space during their inpatient stay, while nurses could continue observational checks on their wellbeing. The room had comfortable seats, murals and displays, a television, books and games.

- Parents were encouraged to stay with children while on the ward and there was a parent's sitting room on the ward providing bread for toast and hot drinks. In the paediatric admissions unit there was a vending machine available and staff offered a tray of sandwiches in the afternoon to parents in the waiting area. •There was a parents' shower on the children's ward which frequently leaked and this would be reported, fixed and then break down again. This was reported as an ongoing situation.
- Children attending day case surgery could be accompanied by their parents from the ward. A small number of day case procedures took place in the main adult day case area, these were primarily for dental and orthoptic needs. A paediatric nurse from the children's ward accompanied children and parents for these appointments.
- The children's outpatient department had a dedicated area at Royal Preston Hospital where there was a large waiting room, with play area and equipment. Some children were seen in the general outpatient areas for Ear Nose and Throat and Orthoptic conditions, so they could be assessed with the correct specialist equipment
- Children's outpatient clinics were also held at Chorley Hospital, covered by nursing and consultant staff from the Royal Preston Hospital. There was a separate children's clinic area within the main outpatient department with adequate seating and toys available. Administrative staff managed all referrals to children's outpatients in order to provide convenient local access for parents, where possible.
- The main children's out-patient area at the Royal Preston Hospital offered a rapid access clinic for parents who needed urgent appointments or follow up advice. Whilst on inspection we saw that one appointment was offered for a patient to attend a rapid access clinic on the same day.
- The children's out-patient department operated a "one-stop model" with blood tests, X-rays and other investigations completed at one appointment session, where possible
- A paediatric gynaecology clinic had been developed within the children's outpatient department so that children could be seen in a more appropriate environment.
- Diabetes clinics that were held in children's outpatients were age related, including for ages under 12 years, 13-15 years,16 years and above. Clinic appointments for over 16 year olds were available in the evenings or after college.
- There was a parents' only waiting area on the neonatal unit where refreshments were provided and meals were also provided for breastfeeding mothers. There was hotel accommodation on the hospital site for parents to use free of charge whilst their babies were on the neonatal unit.
- The environment on the neonatal unit was tired and cramped, however funding had been obtained and work was underway to redesign the area. Parents from the unit were involved in this initiative, together with design students from a local university.
- A quarter of all patients seen in the specialist mobility centre were paediatric and a specific child friendly wing was being developed in the centre. In the existing facility there was a spacious and child friendly play room with soft play area and staff saw children in a separate room for appointments. There was also a separate paediatric cubicle for hand therapy, however patients may have to walk past adults in the department who may have trauma or burns in order to access this area

Access and flow

- Data from the trust indicated that between June 2015 and June 2016, 98.95% of patients referred to paediatric services were seen within the 18 week target, achieving above the national target of 92%.
- The median length of stay on admission was zero nights, compared to an England average of one night.
- The children's ward was open 24 hours and patients were admitted to the ward from the accident and emergency department and primary care, including referrals from GPs or the Community Children's Nursing Team (CCNT).
- Some children who had highly complex needs and disabilities had open access to the ward in case of urgent need. Staff reported there were frequent and lengthy delays in discharge for children with complex needs who were awaiting packages of care in the community

Services for children and young people

- Children's outpatient's clinics were managed by administrative staff from Royal Preston Hospital and allocated to Preston or Chorley clinics depending on their address. Referrals were made via the GP gateway centre to the referral management centre, with many also coming directly to Royal Preston Hospital for choose and book appointments.
- An Advanced Paediatric Nurse Practitioner (APNP) and a trainee APNP were based in the Paediatric Assessment Unit (PAU). Staff reported that this role was effective towards managing patient flow by supporting timely transfer to the children's unit, referral to CCNT or discharge. There were plans for two further APNPs to complete training over the next 18 months
- We were told that when the day case is busy there can be pressure to find a bed and children may sometimes have to go to the ward whilst they waited.
- Children referred to Child and Adolescent Mental Health Services were usually seen on the following working day, however staff reported significant delays in accessing specialist in-patient beds for children when required.•We observed that relevant information in patients' discharge summaries were completed and sent to GPs in a timely way although sometimes there were delays in following up discharge letters from other specialities, such as ENT or plastic surgery.
- The CCNT provided a five day service for children at home, however at weekends children requiring intravenous (IV) therapy and other ongoing treatments needed to come back to the ward for continuation of their care. The CCNT also held community clinics for common children's conditions, including asthma, eczema and constipation.
- Nursing staff from CCNT liaised well with staff on PAU, covering the treatment room to provide evening cover for dressings and other nursing care. CCNT staff reported that they were working to develop supported early discharge and prevention of readmission for children after they were discharged.
- There was effective discharge planning in the neonatal unit with a weekly discharge planning meeting supported by follow up from the neonatal community outreach team. On occasions there could be delays in transferring babies to their local hospital unit due to staffing issues at the receiving hospital.
- In PAU parents reported varied experiences of waiting times. One parent advised that they were triaged straight away and then saw a doctor within 40 minutes, however another parent not been seen by the triage team following admission from the emergency department and was still waiting after an hour.
- Another parent of a child who had complex needs had 24 hour open access to the ward and had been using these services for a year. This parent was allowed to stay on the ward next to the child's bed on a fold away bed.
- We heard that during a previous admission to PAU, a family had a long waiting time and were then sent home during the night, with their child subsequently needing to be readmitted to the ward. On a more recent admission however, their experience of waiting times had improved.

Meeting people's individual needs

- Information leaflets were available for parents on the children's unit and outpatient areas, providing advice on a variety of conditions affecting children, such as diabetes and asthma.
- Interpreter and translation services were available for parents whose first language was not English. Ward leaflets were available in Polish, Hindu and Gujerati as standard.
- Transition pathways were in place for children with Diabetes or Cystic Fibrosis moving to adult services. The Paediatric diabetes service hold transitional clinics at both Chorley and Preston sites, with transition preparation from age 13 years, based on a red/amber/green rated " Ready Steady Go" scheme
- Epilepsy & Diabetes pathways had been developed as part of a two year NHS Advancing Quality Alliance (AQuA) project, for the future management of patients undergoing transition from children's to adult services.
- Monthly focus group meetings were held with staff and parents of children who have complex needs. In these, parents were developing hospital passports so that information did not have to be repeated by parents to staff.
- Staff were observed to work hard in providing holistic care for children with complex needs.
- A specially designed and adapted bed had been sourced by the ward for children with complex needs in response to concerns. This provided children who had different disabilities and sensory conditions with a protective and comfortable experience, whilst allowing nursing staff to carry out treatment and care in a safe environment.

Services for children and young people

- There was a designated room on the ward for cancer patients' use called the Edelweiss room.
- We were told that staff working as carers for children who were receiving community packages of care at home were unable to undertake suction procedures for these children in hospital, as hospital policy prevented this.
- A speech and language therapist provided cover for infants and children with feeding and swallowing needs, to the neonatal unit and to children under two years in outpatient clinics and wards. Demand for the outpatient service was reported as very high, with three outpatient sessions and five inpatient sessions weekly at the time of our inspection. There was no back up cover for staff absence if this occurred.
- We were told that the speech and language therapy service was on the risk register as speech therapy and nursing staff felt that five sessions was not adequate to cover the ward. There was no provision for infants over two years at Royal Preston Hospital or in community services.
- Provision from specialist paediatric physiotherapist services to the children's ward and neonatal unit was on a limited basis. Staff working in areas of general physiotherapy also responded to paediatric referrals, with some reporting they lacked confidence in paediatric skills. Physiotherapy staff reported there was a high level of call out by nursing staff from the children's ward for physiotherapists to undertake respiratory suction procedures as nursing staff didn't feel competent in these procedures also. During our inspection, the trust responded to the concerns identified with an action plan, including a staff training programme, to be implemented with immediate effect.

Learning from complaints and concerns

- Complaints were at low level and mostly about communication and waiting times on the children's ward. Staff were aware that parents may be highly sensitive if their child is unwell so parents were encouraged to complete complaints if they were waiting a while to be seen.
- On the neonatal unit complaints were also at a low level. Staff advised that the visiting policy is currently under review in response to the issue of siblings visiting the unit. At the time of our inspection, parents were given open access visiting, whilst other visitors were restricted to an hour per day.
- Patient advice and liaison service (PALS) leaflets and information were readily available on the ward. The patient experience advisor liaised closely with PALS and ward staff to help resolve complaints in the first instance, with further action from the Ward Manager and Matron when this support was required.
- A patient experience display board on the children's ward displayed "you said-we did" information, including positive comments, such as 'numerous thank you letters' and negative comments such as 'waiting times PAU'.
- The display board also indicated responses to previous complaints, which included installing a vending machine on PAU, providing improved play equipment and increasing the number of APNPs on shifts to improve patient flow.
- Information about complaints and shared learning was communicated by managers in emails to staff as well as in team meetings. Data about complaints and concerns was presented in a Quality and Safety report, discussed at a monthly paediatric governance meeting. During March to June 2016 there were a total of six complaints and nine concerns from both the neonatal and children's unit, with evidence of actions taken in response

Are services for children and young people well-led?

Requires improvement

At the last inspection in July 2014 we rated well led as good however at this inspection we well-led as requires improvement because:

- Changes in leadership and structure for the children's and neonatal areas had been in place since January 2016 and were relatively new and not well embedded at the time of our inspection.
- Staff at all levels consistently reflected the challenges faced in these service areas, particularly with regard to levels of nursing staffing. This was escalated and reported on a daily basis and was reported on the paediatric risk register.
- During the last twelve months, we were told that a total of twelve nursing staff had left on the children's ward,

some in response to nursing pressures. Recruitment had begun in response to the paediatric staffing paper; however some staff said this would add to pressures in the short term whilst staff were settling into new roles.
- Staff broadly knew the trust's vision and values, however were unable to describe any long term plans for the children's unit

However;

- Staff at all levels reported that the new management team had made positive changes and there was a good feeling of staff engagement as a result.
- Nursing staff said that senior leaders were visible on the ward and that paediatric and neonatal issues were being acknowledged, staff felt they were being listened to.
- Staff were committed to delivering the best care that they could to provide for patient needs, working hard to support each other, despite difficult and demanding circumstances day-to day
- There were areas of service innovation, with development of a centralised paediatric resuscitation store for which the children's ward had won a trust business acumen award.
- There was engagement between parents on the neonatal unit and design students from a local university in development plans for the parent's area on the neonatal unit.

Vision and strategy for this service

- Paediatric services were delivered under the hospital's medical division, with leadership from the Matron, supported by the children's Ward Manager. Neonatal services were delivered under the hospital's surgery division, with leadership from a Matron who was supported by the Ward Co-ordinator. Changes in these leadership structures had been implemented during January to April 2016 and so were relatively new at the time of our inspection.
- There were close operational links between the children's ward, Specialist Business Manager and the Head of Nursing, with daily communications about staffing levels and regular service updates ongoing. Daily staffing updates were provided to the Matron in neonatal services, together with weekly team leaders meetings.
- Senior managers acknowledged the challenges that were currently in children's and neonatal services, particularly with regard to nurse staffing and the paediatric assessment unit (PAU) and were progressing actions towards resolving these issues. The long term vision for the children's ward was to re-locate the PAU to be nearer to the emergency department, supported by separate staffing, however there were no detailed plans in place for this at the time of our inspection.
- Senior managers in children's services identified the issues that were raised by staff regarding patients with Child and Adolescent Mental Health Services (CAMHS) needs and children with complex needs awaiting community packages of care. There had been initial progress and meetings held with the CAMHS services and local commissioners to discuss these issues.
- Staff made reference to a trust initiative during 2015 called 'The Big Plan; however there was nothing actively progressing in relation to this that staff were aware of.
- Staff we spoke with were able to describe the trust's vision and values in broad outline, but were unable to describe any vision for paediatric services.Governance, risk management and quality measurement
- A joint neonatal and paediatrics report was discussed at the monthly paediatric governance meetings. The Risk Manager also reviewed risk, quality and safety reports at this meeting, including related discussions about incidents and the lessons learned from these. We saw from monthly meeting records that nurse staffing was indicated as a continued risk.
- A monthly patient safety and risk report was presented to the trust board further to a joint neonatal and paediatric governance meeting. These meetings were attended by key leads in paediatrics and neonatal areas, including business managers, governance leads, consultants, matrons and nursing managers.
- A risk register was maintained which identified ongoing risks in neonatal and paediatric services. The risk register identified insufficient staffing levels on the neonatal unit and children's ward, also the pressure on high dependency care beds in the children's ward.
- Issues noted in the quality and safety report also highlighted some of the concerns expressed by staff regarding patients with CAMHS needs. Staff at ward level advised how these issues had been escalated to trust executive leaders, who had involved ward staff in further discussions. There had been initial meetings with CAMHS and community teams and external services, to identify future plans for this area of provision.

- Team meetings were held every four to six weeks in children's outpatients and the children's outpatient manager attended weekly team leaders' meetings, sharing information with staff from these. The Matron attended the children's outpatients department on a weekly basis.

Leadership of service

- Nursing staff told us that senior leaders had been more visible on wards and staff now felt they had been listened to. We heard from a number of different sources that there has been change since new leadership has been in place, with new managers described as proactive and engaging well with staff. Staff had welcomed the new managers and a couple of meetings had been held to address and discuss issues on the ward.
- Nursing managers said that the issues in paediatrics, particularly regarding staffing levels, were acknowledged 'from the top' and that the Director of Nursing had competed shifts on the ward earlier in the year. Other staff said that this and other engagement meetings had only happened in response to the ward reaching crisis point during earlier months of 2016. During this time, a large number of nursing staff had left the trust and it was reported that overall 12 members of nursing staff had left during the past 12 months.
- We heard that initial recruitment of staff had been undertaken in response to the paediatric staffing paper and that there were new staff starting in nursing posts over October and November 2016. Some staff told us this would bring more change and pressure in the short term. Managers were aware of this, with ongoing monitoring and plans were in place to support staff appropriately.
- Generally staff commented that there were good working relationships between staff and departments and consultant paediatricians were accessible and helpful. A number of comments from staff indicated that links with community services needed to be strengthened.
- Ward meetings were held monthly for nursing staff and staff were rostered to attend. However, attendance at these was often difficult for all staff, due to working demands on the ward. Email communications were circulated weekly by the Ward Manager to all nursing staff, providing bullet point summaries of update information.
- Staff in speech and language therapy service said they had received good support from the Business Manager for identifying their service development needs in paediatrics.

Culture within the service

- Staff we spoke with gave an open and honest picture of the day to day demands that they faced within paediatrics and neonatal areas. This was reflected at all levels, from consultants, managers and nursing staff. We heard staff say 'we don't do ourselves any favours by not closing to admissions'.
- Nurses commented that working demand had been high and morale had been low, that there has been a lot of change and that this could also bring difficulty. However, we also heard from many staff that they felt more reassured since new management had been in place.
- Staff we spoke with demonstrated their clear commitment to delivering patient care as they best could, whilst facing demanding and difficult circumstances day-to-day. We observed that staff in neonatal and children's areas worked hard to support each other and ensure that patient needs were met. There was a strong culture of team working evident in day to day working practice.

Public engagement

- There was no NHS Friends and Family Test information available for the children's ward and neonatal unit, however, feedback from patient and parent feedback forms was collected.
- We observed 'You said, we did' noticeboards on the children's ward and a parent group were involved in redesign of a parents area on the neonatal unit. Design students from a local university were involved in this collaborative work.•A volunteer working on the children's ward was a wheelchair user and had received awards for their work.
- A parents' group for children and young people with complex needs met once a month with staff to discuss developments in providing for this area of care.. A patient passport for children who had complex needs was being implemented from this.

Services for children and young people

Staff engagement

- Staff felt they were involved and engaged in developments on the children's ward, outpatients area and neonatal unit. Results from the NHS staff survey were largely the same as other trusts in the 2015 staff survey.

Innovation, improvement and sustainability

- Within the twelve months prior to our inspection, paediatrics had won two quality awards, one for the neurology team for their transitional service and the other for a volunteer worker on ward 8.
- The children's unit had won a trust business acumen award for establishing a paediatric resuscitation store as a centralised facility within the trust.
- A paediatric tracheostomy training course, open to internal and external candidates, had been developed, with the support of the simulation team. The paediatric unit had opened a paediatric simulation suite on the paediatric unit, available for training of all multi-disciplinary teams.
- Future development was identified to facilitate the training of three staff to complete their Advanced Paediatric Nurse Practitioner course.
- Through a joint working approach, the children's ward and emergency department had identified plans for establishment of rotational nursing posts, to provide cover and continuity between these departments.

End of life care

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

Information about the service

End of life care (EOLC) was delivered by nursing and medical staff throughout the Lancashire Teaching Hospitals NHS Foundation Trust. There were no dedicated beds within the hospital for palliative care. The specialist palliative care team (SPCT) were part of a multidisciplinary team approach to end of life care and worked across the two trust sites at Royal Preston and Chorley and South Ribble Hospital. The team provided information to patients and staff regarding diagnosis and treatment and offered specialist advice on the management of difficult symptoms. The Specialist Palliative Care Team (SPCT) delivered a Monday to Friday 8.30am to 4.30pm service, with advice available out of hours and at weekends from palliative care staff at the local hospice.

There were 1383 deaths recorded for Lancashire Teaching Hospitals NHS Foundation Trust between 1 April 2015 and 31 March 2016, of which 62% were cancer related. The palliative care team received referrals for 485 patients.

When we previously inspected the trust in July 2014, we rated the safe, effective, caring and well led domains in EOLC as 'good' and the responsive domain as 'outstanding'.

During this inspection, on the Royal Preston Hospital site, we visited 11 wards where end of life care could be delivered, the mortuary, chapel, bereavement suite, porters and medical devices library.

We spoke with 25 staff, including the clinical nurse specialist, ward nurses, porters and mortuary staff. We looked at the health care records of 17 patients that were either palliative or receiving end of life care.

At Chorley and South Ribble Hospital, we visited six wards, the mortuary and the chapel. We spoke with 11 staff including the discharge coordinator and examined six health care records of patients that were receiving palliative or end of life care.

End of life care

Summary of findings

At the previous inspection in July 2014 we rated this service as good overall at both hospitals. At this inspection we will only report on End of Life services within the Royal Preston Hospital report as the service delivered is by the same team across both hospital sites, however we did inspect both hospital sites. Following this inspection we have maintained this good rating because:

- There was good use of the individualised plan of care document throughout the hospital. All health care records were completed to a high standard to ensure patient safety. There was evidence of comprehensive risk assessments regularly performed and patients' goals and wishes were recorded.
- There was evidence of changes and improvements made as a result of feedback from patients and other staff.
- The palliative care team delivered training to all levels of staff, using a variety of teaching methods to capture the maximum staff available. Online guidance was provided via the trust intranet that ensured all staff had access to the most current information at all times.
- The end of life care (EOLC) team demonstrated excellent management of patients in their last days/ hours of life. The team had used the National Institute for Health and Care Excellence (NICE) Care of the Dying guidance to develop a 'Think CLEAR' policy for all staff to follow. The team had performed on or better the national average on 11 out of 13 of the key performance indicators on the 2016 Dying in Hospital Audit.
- The team attended daily multidisciplinary team meetings across the hospital specialities in order to provide knowledge and input into patients' end of life care. The hospital team also participated in local and national groups to share information and learn from peers.
- Staff respected patients and their relatives and valued them as individuals. The care provided by the palliative care team was person centred and the culture within the team reflected this. All interactions between staff that we witnessed were patient centred and displayed compassion and respect.

However;

- The team were not providing a seven-day palliative care service that meant rapid discharge between Friday and Monday could not always be facilitated. This meant that some patients may not die in their preferred place.
- The staffing levels for the bereavement and donor team had reduced and therefore the success of the service was in decline.
- The educational facilitator was having difficulties ensuring an end of life link nurse was available on every ward, due to staff movement within the hospital.
- Staff compliance with mandatory training and appraisal was below the trust target.

End of life care

Are end of life care services safe?

Good

At the previous inspection in July 2014 we rated safe as good. Following this inspection, we have maintained this rating because;

- The specialist palliative care team (SPCT) demonstrated they knew how to record incidents and were proactive in seeking out incidents throughout the hospital where they could make improvements to improve safety.
- There had been improvements and education of nursing and portering staff since the last inspection regarding the transport of bodies to the mortuary. There had been no further incidents of this nature reported.
- There were safe systems in place to protect staff from healthcare associated infections. Infection prevention methods were used in the mortuary and all areas were clean and well maintained.
- There was excellent guidance on medication prescribing available to clinicians via the end of life intranet portal. All records we inspected contained appropriate prescriptions following national recommendations.
- There was good use of the individualised plan of care document throughout the hospital. All health care records were completed to a high standard to ensure patient safety.
- Patients were assessed for their risk of falls, nutrition, hydration and pain regularly to ensure they remained comfortable as their condition deteriorated.
- There was 5.4 whole time equivalent specialist palliative care nursing staff to work across the two hospital sites. This number allowed face- to-face contact to be available Monday to Friday 8.30am to 4.30pm. There was also a dedicated educational facilitator and a bereavement and donor team.
- Interviews were due to take place for a second palliative care consultant in the coming month. This post would ensure there would be sufficient medical cover across the two hospitals.

However;

- The mandatory training figures for SPCT staff was below the trust target in a number of areas including safeguarding, basic and advanced life support, and some infection control techniques.

Incidents

- The trust had an electronic system for recording incidents that was available to all staff via the intranet. Palliative care and mortuary staff told us they were familiar with the reporting system and gave us appropriate examples of when they had used it. There was evidence on the trust incident recording system of its use.
- As the National Reporting and Learning System does not have a specific end of life category, the palliative care team had worked to identify risks and incidents that involved their care in order to analyse, learn and improve.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood duty of candour and their responsibly to be open and transparent.
- There were no serious incidents recorded relating to end of life care between 1 April 2016 and 31 July 2016.
- At the last inspection there had been six incidents recorded regarding infection control relating to transfer to the mortuary. We saw evidence that training had taken place within portering services, procedures and processes had improved and safe systems were used. We spoke with porters and mortuary staff who confirmed no further incidents had occurred.
- Staff had a process of using a red armband when two deceased patients with the same name were brought to the mortuary. This additional identifier ensured that staff took extra care when transferring bodies.
- As a result of an incident involving a hospital porter, the mortuary manager completed a risk report to highlight the need for additional load bearing trolleys. The department then purchased an electronic trolley that could accommodate bodies of obese deceased patients and an electronic hoist. Procedures and training were put in place to keep staff safe.

Medicines

- There was a comprehensive guide to prescribing medication for patients at the end of their life. The guide was accessible to all staff via the palliative care portal on the hospital's intranet. Information included specific

symptom control and dosage guidance algorithms with separate hyperlinks for specific conditions, such as renal impaired patients. Medical staff told us they knew where to access anticipatory prescribing information.
- Medication considerations, including current and anticipatory medicine, was available in the clinical guideline 'Dying – Providing Care for Adults in the Last Days of Life' which had been locally adapted from NHS England guidance.
- In the 23 medication administration records we examined, all medicines were prescribed appropriately in line with National Institute for Health and Care Excellence (NICE) guidelines. We saw evidence of medicine management plans, for example diabetes maintenance, and good symptom control management.
- There were no issues with provision of syringe driver medication. Syringe drivers were available for staff on wards when required. The hospital's medical devices library was responsible for cleaning, maintenance, storage and supply of syringe drivers to wards.
- At Chorley and South Ribble hospital staff knew where to collect and return the syringe drivers to enable the medical devices department to service, clean and maintain the equipment. We were told that any drivers that accompanied patients to the hospice were collected by hospital transport and patients discharged home, were given a bag to accompany the item for its return.

Records

- The SPCT had developed an individualised plan of care (IPOC) for the last days of life, which recorded the care, treatment and wishes of the patient leading up to and at the point of death. As part of the National Care of the Dying Audit published in March 2016 the hospital had recorded that 58% of health care records contained a holistic plan against a national average of 66%.
- At the time of the inspection, the newest version of the IPOC had been in place for approximately one month. We saw the completed document in place in all but two records (88%) and the quality of information was high.
- There was evidence of comprehensive risk assessments in health care records that ensured patient safety, including falls, nutrition/hydration and pain assessments. The patient's condition was assessed daily.
- We saw that health care records were stored securely to ensure they could not be accessed by people who did not have the authority to do so.
- Information Governance training was part of annual mandatory training for all staff. The palliative care team achieved 77% compliance from October 2015 to September 2016. The trust target was 80%.
- There was an Electronic Palliative Care Coordination Systems (EPaCCS) project ongoing with the trust and primary care working together to improve the patient record system and provide continuous care.

Safeguarding

- Staff were knowledgeable about the trust's safeguarding policies and their role and responsibilities. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.
- The trust had mandatory safeguarding training programmes in place for staff as part of their initial induction. The training data showed that the SPCT achieved 70% compliance for safeguarding adult's level two and 43% for level three against a target of 75%. The figures for safeguarding children level one was 100% and level two was 67% (three staff), against an internal target of 90%.

Cleanliness, infection control and hygiene

- All wards we visited were visibly clean. Staff followed infection control guidance, including the 'bare below the elbow' policy. We saw staff using hand gel and wearing personal protective equipment, such as gloves and aprons appropriately.
- We visited the mortuary at both Royal Preston Hospital and Chorley and South Ribble and found it was clean and well maintained. Cleaning procedures were in place and we saw evidence of compliance. Good hygiene practices, sufficient protective equipment and hand washing facilities ensured infection prevention.
- The facilities in the mortuary allowed isolation of any known infection risks and staff were aware of processes to maintain safety of staff and visitors.
- The SPCT participated in aseptic non-touch technique training and 70% had completed training between October 2015 and September 2016, which was worse than the trust target of 85%. Two staff had also

undertaken Antimicrobial Stewardship training (a course designed for staff to understand the use of antibiotics and the help reduce the occurrence of antimicrobial resistance).

Mandatory training

- Mandatory training was provided for all hospital staff on an annual rolling programme and included health and safety, infection control and resuscitation. For the period October 2015 to September 2016, 77% of palliative care staff had undertaken the trust mandatory training, against a target of 80%. There were 14 members of the palliative care team.
- Some training, such as intermediate life support, was dependent on staff grade and responsibility and only appropriate for one member of staff. This meant compliance figures were largely affected by staff attendance. For example, figures would change from 0% to 100% if one staff attended.
- Based on the information provided, there was a red status, meaning not compliant, with trust targets in 17 out of 27 subjects. The team were non- compliant in adult basic and advanced life support, conflict resolution and care of the dying, advanced care planning and think clear training.

Assessing and responding to patient risk

- We saw comprehensive risk assessments, including national early warning scores, completed in healthcare records daily, which alerted staff to a patient's deterioration and ensure appropriate action was taken.
- Staff on the wards could contact the SPCT Monday to Friday for a patient referral or telephone advice. There was also the Palliative care portal and the local hospice available for out of hours advice.
- Ward staff told us the SPCT had a visible presence on the wards. Any changes to a patient's condition triggered a visit by the SPCT. We saw patient's notes completed daily by nursing, medical and therapy staff with updates on any changes to condition.

Nursing staffing

- The SPCT included 5.4 whole time equivalent nursing staff to work across the two hospital sites. This number allowed face-to-face contact to be available Monday to Friday 8.30am-4.30pm. Chorley and South Ribble Hospital was staffed on a six-month rotational basis. Ward staff were positive about the amount of support they received from the team and knew how to access information out of hours.
- At the time of the inspection, we were told that funding was secured and vacancies advertised for two further nursing posts. This would facilitate an increase in service to seven day working.
- The donor team had decreased in numbers from four substantive staff to two. During the inspection, the team were experiencing difficulties with one member away with a long-term sickness. The impact of this meant that the number of retrievals had reduced as a direct result from 202 between 1 April and 30 September 2016 to 147 between 1 October and 31 March 2016.
- The palliative care team included an educational facilitator whose responsibilities included providing specific end of life training to nursing and medical staff. Their role also included educating the end of life link nurse based on each ward. Ensuring each ward had a link nurse was proving difficult, as nursing staff moved between wards and the facilitator was not always informed.

Medical staffing

- The three consultants in palliative medicine worked across the hospital, hospice and community taking a lead responsibility for particular parts of the service. They were all employed by the acute trust and provided cross cover. The consultants all participated in the 24 hours per day, seven days per week, advice line service based at a local hospice that was accessible across the health economy.
- Specialist palliative medical cover at Chorley and South Ribble Hospital was provided by the three specialist palliative care consultants on a sessional basis. Sessions were arranged so that patients were seen promptly. Doctors held outpatient clinics at Chorley for palliative patients. The consultants ensured specialist advice was available 24/7.
- An additional consultant post had been advertised and plans were in place for the second post to be based at Chorley and South Ribble Hospital as a gap had been identified at regional end of life network groups.
- Medical staff on the wards had access to education via the SPCT facilitator who delivered one-to-one ward based training and via the intranet. Two doctors we spoke with had received some form of EOLC training.

End of life care

Major incident awareness and training

- The trust had a comprehensive major incident plan in place. Senior staff had access to action plans and ensured delivery of essential services was maintained.
- The mortuary held quarterly major fatalities exercises in conjunction with local emergency services. Additional equipment and facilities were available at Chorley and South Ribble Hospital. The facilities at Chorley and South Ribble Hospital were spacious and had ample body storage in the fixed fridge unit, which included storage in an emergency situation.
- All facilities and equipment in the Chorley mortuary were regularly cleaned and serviced in preparedness for a major incident.

Are end of life care services effective?

Good

At the previous inspection in July 2014 we rated effective as good. Following this inspection. we have maintained this rating because:

- The end of life care (EOLC) team demonstrated excellent management of patients in their last days/hours of life. The team had used National Institute for Health and Care Excellence (NICE) care of the Dying guidance to develop a 'Think CLEAR' policy for all staff to follow.
- The team had performed on or above the national average on 11 out of 13 of the key performance indicators on the 2016 Dying in Hospital Audit.
- All ward staff had access to the End of Life portal that was maintained and updated by the palliative care nursing staff. This included clinical guidance, best interest and prescribing information.
- We saw assessment tools in healthcare records that were appropriate to end of life care. Nutrition, hydration and pain assessments were performed using nationally recognised tools. Pain relief had been managed appropriately in all cases.
- All but one of the healthcare records inspected had an appropriate, complete Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) document in place. We saw evidence where a patients capacity to make decisions had been assessed, and best interest discussions with family where appropriate.
- Excellent examples of multidisciplinary working were seen.

However;

- The specialist palliative care team were still unable to offer a seven-day service to patients, though we were told this was being addressed.
- The staff appraisal rate for the palliative care team was below trust target of 85%.
- The numbers of registered nurses who had completed end of life training was below the trust target. The palliative care team had plans to address this.

Syringe driver training figures were not routinely collected and therefore no assurance of competency could be provided.

Evidence-based care and treatment

- The trust had developed and implemented a person centred holistic nursing plan to assess and understand each patient's individual needs. The document in its current form had been in use for a month at the time of the inspection. However person centred care planning had been in place since the use of the Liverpool Care Pathway had ceased.
- This individualised nursing care plan facilitated assessment of patients' needs in line with best practice and National Institute for Health and Care Excellence (NICE) guidance. The document included general needs, such as visual or hearing problems, nutrition and hydration assessments and spiritual wishes along with any other health issues.
- A clinical guidance document was available to all staff caring for dying patients. The document 'Dying, caring for patients in the last days of life' had been developed in consultation with the hospital consultant, palliative care team, EOLC steering group, board and clinical advisory committee. The document was adapted from NHS England guidance.
- Staff had access to current policies and procedures via the intranet portal. A member of the team had responsibility for ensuring documentation was up to date and in line with current guidance.
- The hospital continued to deliver care using the amber care bundle known as 'Think Clear'. This included management plans for patients with uncertain recovery and rapid discharge processes for patients at the end of life, following NICE Care of the Dying guidance.

End of life care

- Local audits performed in the last 12 months included 'Care of the Dying at LTHTR Re-audit'; to monitor effects of the trust guidance on patient care, pain management and a bereavement questionnaire was performed four times a year.

Pain relief

- Specific pain guidance was available to all prescribers in the form of a flow chart attached to the clinical guidance document 'Dying – Providing Care for Adults in the Last Days of Life' and included name, form and dosage information.
- We saw recognised pain assessment tools evident in all the healthcare records we inspected. Pain assessments were completed and medication was provided where required.
- Palliative medication, including pain-relieving medication, was available on the wards we visited and prescribing in anticipation of deterioration was appropriate.
- We saw evidence of specific analgesia considerations made for a patient with renal disease in one set of patient records.

Nutrition and hydration

- The Dying in Hospital audit (March 2016) demonstrated that the assessment and support for oral hydration and nutrition was better than the national average. There was more input by the speech and language team and Lancashire Teaching hospital staff had more discussions with patients and relatives about hydration and nutrition.
- Nutrition and hydration had been monitored in the follow up re-audit in July 2016. The number of patients with a documented nutrition and hydration plan had increased from 35% in 2013, 44% in 2014 to 50% in 2015.
- The individualised nursing care plan included considerations such as difficulty swallowing, denture wear and providing eating and drinking aids. Family involvement in patient care was important and wishes or requests were included in the document.
- We saw evidence of daily nutrition and hydration assessments in healthcare records including comments and plans using the 'Malnutrition Universal Screening Tool' ('MUST'). Mouth care was also appropriately considered.
- Staff told us specialist input from dietician and speech and language therapists was available on all wards and we saw evidence of their input in notes.

Patient outcomes

- The SPCT had developed an end of life dashboard to record and monitor information locally that allowed audits to be undertaken and performance monitored.
- Results from the National Dying in Hospital audit, reported in March 2016, indicated that the hospital performed well in 11 out of 13 of the key performance indicators. The trust demonstrated national average results in the clinical indicators and answered 'yes' to the six organisational indicators.
- However, the trust did not have an EOLC lay member on the trust board and access to specialist palliative care was not available seven days per week. There were plans in place to increase the number of palliative nursing staff. We were told by one member of staff that there was now a lay board member with EOLC responsibility but senior staff were unaware of this when asked.
- In addition to the key indicators, the hospital had scrutinised the results against national standards and against the nearest four acute trusts. Where improvements could be made, a set of recommendations had been made by the palliative care consultant. We saw some of these recommendations implemented during the inspection, for example, increased access to education and training of staff using the new care plan.
- In Chorley hospital, the SPCT were creating a process for case note reviews. The staff explained that they intended to look at gap analysis and unmet need within the hospital, including the effects on the community teams. The plan would provide awareness of any missed opportunities and lead to improved services.

Competent staff

- The SPCT appraisal rate for October 2015 to September 2016 was 62%, this was worse than the trust target of 85%. The staff we spoke with during the inspection stated they had received their performance review and staff sickness accounted for the low number.
- The educational facilitator was responsible for providing end of life training for all trust staff. Training methods included classroom, on the ward and online, in order to capture the maximum number of staff available.

End of life care

- Training needs analysis was recorded on the EOL dashboard to monitor staff numbers for the Transforming end of life care initiative. Advanced care planning, Think Clear, Sage and Thyme, Care of the Dying and Rapid Access to Homecare training was delivered. The trust target was 70% and only 51% of medical division registered nurses and 29% of surgical registered nurses had attended. The team were addressing this by creating alternative training bundles that could be accessed from the intranet and undertaken on the wards.
- A three hour training programme was provided for staff during their preceptorship period and third and fourth year medical students at the hospital.
- As a result of feedback from bereavement questionnaires, the advanced communication training 'Sage and Thyme' was offered to all hospital staff.
- Porters followed a procedure when performing bereavement duties that included equipment and health and safety requirements. We saw evidence that training had taken place and two porters we spoke with said they had received adequate training
- The specialist palliative care nurses were supported by the trust to become nurse prescribers. Additional training, also delivered, included spiritual awareness, advanced communication, nurse verification and syringe driver use. The bereavement team offered a holistic care training course supported by Lancashire and South Cumbria Cancer Network.
- Although syringe driver training was delivered, the nurse facilitator told us that numbers were not recorded and so there was no assurance of competence on each ward. Work was already underway to address this.
- Mortuary staff told us they were fully supported to continue their education within their roles. The department had recently begun an apprenticeship programme and had a trainee who also worked in pathology. Staff had undertaken level three or four in Anatomical Pathology and one staff member was studying for a degree in Mortuary Science at a local university.

Multidisciplinary working

- The SPCT told us they benefited from good working relationships with staff at the hospital and in the community. Staff on wards spoke positively about the input from the SPCT.
- The palliative care team participated in meetings every day throughout the hospital in order to facilitate early referrals and provide continuity, advice and support to ward teams on patient care. These meetings included ward rounds in oncology, respiratory and medical assessment units, surgeon of the week meetings and the gold standard framework aqua meeting to facilitate community referrals.
- The palliative care team hosted weekly multi-disciplinary team meetings, which included all staff involved in palliative patients' care including allied health professionals and community teams. The meetings facilitated referrals for discharge planning and highlighted vulnerable patients with the social worker. The meetings were also used for peer review of clinical practice, clinical supervision and promotion of learning programmes.
- The bereavement team worked well with the palliative care team in recognising patients and relatives' needs and worked together to meet them. However, the chaplain felt that they had capacity to be more involved with the work of the bereavement team.
- The palliative care team had regular weekly video conference meetings with staff at the hospice and every three months with the community teams to discuss mortality and any route cause analysis that might lead to improvements across the wider locality.
- Palliative care staff told us they had close contacts with other specialist nurses, for example the heart failure nurse, to raise awareness of patients that were deteriorating.
- Mortuary staff liaised regularly with staff from neighbouring trusts to share knowledge and learning.

Seven-day services

- The SPCT team did not offer a seven-day service and provision was Monday to Friday 08.30am to 4.30pm.
- Plans were in place and jobs advertised to increase the SPCT by two additional nurses in order to move to a seven-day service.
- Information and advice could be sought out of hours, by telephone, from the local hospice and staff on wards were aware of this and how to contact them.

End of life care

Access to information

- We looked at the records of 23 patients identified as at the end of life. We spoke with staff who confirmed risk assessments were available and staff had all of the information they needed to deliver effective care in a timely way.
- We saw documentation available for staff to record patient's decisions around advance decisions, spiritual needs and hydration, which was integral to the individualised nursing care plan.
- The End of Life portal on the intranet provided all the information and guidance required to care for a patient on the ward. Staff could access documentation and contact numbers along with clinical guidance and procedures.
- On discharge, patient's end of life care information was recorded in the discharge summary and transferred to the GP Electronic Palliative Care Coordination System's (EPACC) template. Patients who were discharged from hospital using fast track continuing healthcare (CHC) funding are flagged on the electronic patient record, which alerts if they are readmitted. This also generates an automatic referral to the palliative care team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had documentation in place that considered each patient's capacity and consenting ability. In the document, 'Providing Care for Adults in the last days of life Individualised Plan of Care Initial Medical Assessment' medical staff commented on the patient's condition.
- Staff understood the consent and decision making process, and were able to explain how people were supported to make decisions. Consent training had been undertaken by Specialist Palliative Care Team (SPCT) staff as part of mandatory training.
- We inspected 17 completed 'allow natural death' or Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms during the inspection. All but one was completed correctly and compliant with policies and guidelines. The documents were signed, dated and legible. Two patients had a community and a hospital DNACPR in their records. Only one record was incomplete. The capacity assessment was not complete and had not been signed by a senior clinician.
- There was evidence of discussions with the family and best interests decisions being made where the patient lacked capacity to respond.

Are end of life care services caring?

Good

At the previous inspection in July 2014 we rated caring as good. Following this inspection we have maintained this rating because:

- Patients were treated with dignity and respect both on the ward and in the mortuary.
- We saw a number of thank you cards in the bereavement suite and on the wards from relatives.
- The bereavement team told us how they encouraged family to spend time with the dying patient and created special memories.
- Patients and family were involved in the decision-making process and the team were proactive in ensuring that wishes were achieved.
- The chaplain provided emotional support to the patients and family and gave us many examples where this had happened.

Compassionate care

- During the inspection, we saw many thank you cards both on wards, in the bereavement suite and in the mortuary for the care and treatment of relatives. We were given examples where patients' wishes were met and supported by the chaplaincy and the bereavement staff.
- Staff respected patients and their relatives and valued them as individuals. The care provided by the palliative care team was person centred and the culture within the team reflected this. All interactions between staff that we witnessed were patient centred and displayed compassion and respect.
- Wherever possible, patients at the end of their life had single bedrooms on the wards. Friends and family were encouraged to stay and home comforts were encouraged, for example duvets and pillows. Staff were sensitive and supportive to their needs.
- We visited the mortuary where staff displayed their passion about providing a caring and compassionate approach to their work. They were sensitive to the

cultural wishes of the deceased and were conscientious in providing the support required for some faiths. The staff we spoke with demonstrated a caring attitude to deceased patients. The environment for families to view their deceased was calm and welcoming.

- A bereavement survey carried out in 2015 demonstrated the staff attitude was kind and compassionate with positive comments from relatives, such as "I couldn't have asked for anything more" and "All was done that could be done. I was grateful for the tactful and sympathetic way staff dealt with occasions when we had too many or too noisy visitors"
- We spoke with one inpatient who told us she was happy with her care. She and her husband had been kept informed and staff communication was good.

Understanding and involvement of patients and those close to them

- We saw records of extensive conversations with family by SPCT and ward staff regarding the patient's wishes. There was evidence that staff regularly visited patients and became involved in their care.
- In the healthcare records we inspected, there were specific entries made regarding pastoral care, personal items, such as music and pets, and any other needs or wishes that would comfort the dying person.
- We were given an example of providing individual holistic care for a patient that wished to accompany her treatment with homeopathic remedies. The palliative care team were able to support the patient and discuss benefits, risks and concerns.
- The bereavement and donor staff were able to provide information and support with decisions to donate organs and tissue. Practical advice was available regarding matters relating to death including certification and registration and post mortems.
- The bereavement survey received results from 79 relatives of patients who died between July and September 2015. Ninety-five percent of relatives agreed they had enough privacy during their relatives last hours and 92% stated they had enough involvement in decisions regarding end of life care.

Emotional support

- Bereavement and chaplaincy staff had a visible presence on the wards and told us they had the time to support the patient, their relatives and staff emotionally and spiritually regardless of faith.
- The hospital facilitated bereavement support groups with monthly meetings that offered peer support through free discussion. There were separate groups for bereaved families of both adults and children.
- The chaplain told us how she encouraged parents to complete a memory box when their child had died; she also gave the family a keepsake of a bookmark, a rose or a packet of forget-me-not flower seeds. A memory tree was situated in the chapel and the chaplain provided relatives with paper butterflies to write messages to loved ones and hang on the tree.
- The chaplaincy service provided support with a dedicated team of volunteers. In the event of a member of staff dying, the chaplain arranged a memorial service in the chapel for colleagues and relatives.
- Annual memorial services took place for patient groups that had died at the hospital. These included critical care patients, babies and motor neurone disease sufferers. A whole hospital service had taken place at Preston Church of England Cathedral in 2015.

Are end of life care services responsive?

Good

At the previous inspection in July 2014 we rated responsive as outstanding. Following this inspection we have given a rating of good because:

- Patients reaching the end of life in the hospital had good support from the palliative care team, the bereavement and tissue donation team and the chaplaincy service.
- Staff on wards knew how to contact the teams and where advice could be found if required out of hours. The palliative care educator delivered classroom and ward based clinical training for nursing staff, allied health professionals and health care assistants. An on-line blended learning package was being developed in order to increase accessibility to learning.
- A mortality data review had been completed in July 2016 and demonstrated the time to review a patient from referral was an average of 0.3 days. We were told, on the most recent audit, that less than 50% of patients referred to the SPCT died in hospital because the team were able to facilitate the patients preferred place of death wishes.

End of life care

- The team had developed an individualised plan of care document that allowed care to be tailored to a patient's needs and preferences. We saw examples in health care records of the document in use and guidance for staff online and training sessions.
- All equipment, including syringe drivers, hoists and trolleys were maintained and appropriate for their purpose. Additional load bearing trolleys and hoists had been purchased to transfer larger patients and staff had been trained to use the equipment safely.
- Complaints were managed well and changes were implemented appropriately.
- The spiritual needs of different faiths were accommodated by the chaplaincy service. The hospital had a large purpose built Muslim prayer facility to meet the needs of the local population. The chaplain arranged memorial services for different groups of bereaved families on a regular basis and had facilitated a hospital memorial in Preston cathedral.

However;

- At the time of inspection the specialist palliative care team did not operate a seven day service. This meant that nursing staff relied on a telephone advice line at weekends. Although every effort was made, there were some instances when a patient could not have a rapid discharge to home between Friday and Monday.
- According to an audit, the number of patients who had expressed a preferred place of death (PPD) which was not achieved was 40 (18%). There were also 63 patients whose PPD was unknown.
- Due to the reduced staffing numbers in the bereavement and donor team the number of eye retrievals had decreased. A coordinated approach to holistic care with the chaplaincy service may have been beneficial.

Service planning and delivery to meet the needs of local people

- The trust were committed to providing care for the wider Lancashire population and participated in the Greater Preston, Chorley and South Ribble Palliative and End of life Care Strategy group involving all statutory and voluntary providers and the Clinical Commissioning Groups (CCG).
- The SPCT services across Central Lancashire have begun a joint mortality review process to improve the quality of care and identify any challenges to patient choice in the area.
- The trust funded the palliative care consultants based at the hospice, in the community and in the hospital. This enabled greater understanding of the demands on the service with collaborative working.
- The palliative care team were embedded in all clinical areas across the hospital. Staff were involved in the planning and delivery of services. Staff spoke highly of the advice and support received from the end of life team.
- The bereavement team were partially funded by NHS Blood and Transplant (NHSBT) and the hospital was one of only ten in the UK that participated in an eye retrieval service. Targets were set nationally and Lancashire Teaching hospitals NHS Trust was the top performing trust in the first half of the year, however, due to long-term staff sickness between 1 April 2015 and 31-March 2016 the trust were third in the table at the time of the inspection.
- The palliative care team collected data on the EOL dashboard in order to monitor the service provided and benchmark activity. From January to June 2016, the SPCT saw an average of 36% of patients who had died in the trust.
- The specialist palliative care team had produced a mortality data review in July 2016. The review looked at patients referred to the team over a six month period and examined referral times, preferred place of death and looked for any missed opportunities.
- According to the audit, the number of patients who had expressed a preferred place of death (PPD) which had not been achieved was 40 (18%). There were also 63 patients whose PPD was unknown. Reasons were assessed and conclusions stated that advanced care planning and recognition of dying could be improved.
- The team had a visible presence on the wards and staff told us that access to the team was easy. The SPCT participated in ward meetings, made daily calls for updates on patients and the bereavement nurse carried a bleep.
- Each ward had an EOL champion who was the first point of contact for ward staff requiring specific end of life information. Training was provided by the education facilitator, along with twice-yearly updates.

End of life care

- In Chorley, the community liaison nurse was responsible for co-ordinating the rapid discharge of patients. Her role was to meet with the palliative care team and arrange discharge with community services, if the discharge was appropriate. Care packages and equipment needs were assessed and discussed with the family. Requirements in the home, such as furniture or oxygen supplies were arranged along with any therapy input needs.
- A case manager in Chorley and South Ribble Hospital told us that contact with the SPCT was excellent. The team were responsive to referrals and met the junior doctors training needs.

Meeting people's individual needs

- We heard many examples of patients' needs and wishes being at the centre of the care provided and decisions made. Staff explained that being open and honest was vital to providing end of life care and helping patients achieve the death they wish.
- There were excellent facilities catering for the religious and spiritual needs of patients, carers and staff. The chapel at Royal Preston Hospital was clean, bright and had lots of seating to accommodate a large congregation. A purpose built large multi-faith facility had been a recent addition. There were separate facilities for men and women, with separate washing facilities attached. The multi-faith room had been carpeted with a prayer mat design. All rooms were soundproof.
- In Chorley Hospital, the chapel was smaller, but neat and tidy. The chapel was situated in the centre of the hospital but had large windows that let in lots of natural light. The Chorley chaplain kept a book of remembrance in the chapel for patients who died in hospital. The chapel also provided multi-faith facilities, though these were too small for Friday prayers. The local Muslim community had an arrangement with the chaplain that the main chapel could be appropriately arranged for 45 minutes for Friday prayers each week. This process worked well.
- The chaplains for the two hospitals were on call seven days a week and were able to cover each other's commitments when required. There was regular input from the local Imam who visited the hospital daily. The chaplain had a contact list and arrangements were in place for leaders from other faiths to visit the hospital if required.
- The mortuary had viewing rooms for people to view the deceased. There was a small parking area and a garden with benches for reflection outside. The entrance was on the ground floor and all areas were wheelchair accessible. Inside the rooms were clean, spacious and tastefully decorated. Staff were sensitive to the feelings of the families and prepared the deceased for viewing by using pillows and a duvet on the trolley.
- The mortuary staff did not set a time limit that family could spend with their loved ones and tried to give visitors as long as they needed.
- The mortuary manager had a good working relationship with the local Imam. He had visited the mortuary to discuss the requirements of the Muslim faith regarding funeral arrangements. Plans were in place with the coroner to release the body for burial as soon as possible.
- The trust employed a specialist bereavement midwife to support patients and staff on the maternity and gynaecology wards. Parents were given information for support and provided with photographs and handprints as keepsakes. Staff were sensitive to different cultural and religious needs.
- The storage facilities in the mortuary at Royal Preston Hospital could accommodate 52 bodies with four larger fridges for deceased patients who were clinically obese. Separate isolation areas were used for babies. There was an additional facility on site that could hold 30 bodies or be used as open storage for larger deceased patients.
- The bereavement suite in the hospital contained a number of rooms that were suitable for patients and relatives to discuss emotional issues privately. The rooms had comfortable seating and a 'homely' environment. Information was available from the office regarding practical issues such as registering a death, or becoming a donor to counselling services. There were quiet rooms throughout the hospital that could be used by bereaved families, on the maternity ward and in accident and emergency for example. We saw feedback from relatives that staff had offered refreshments and were given time to grieve

Access and flow

- Patients referred to the palliative care team were seen promptly. A mortality data review had been performed

in July 2016. From 223 referrals, 96.4% were seen within the target of two days from referral with an average wait time of 0.3 days. The most urgent patients were prioritised and ward staff knew how to contact the team.

- We were told, on the most recent audit, that less than 50% of patients referred to the SPCT team died in hospital because the team were able to facilitate the patients' preferred place of death wishes.
- The trust had a procedure for "Rapid access to homecare" for patients in the last week of life. The process facilitated discharge within 24 hours and aimed to be the same day. The procedure included criteria for discharge, key staff involvement, communication and clinical guidance. Outcomes were monitored using the EOL dashboard. Between April 2015 and March 2016, discharge was successfully achieved for 42 patients. The rapid discharge process was commenced for 181 patients in the same time period. This number had increased from the previous year, when only 127 patients had commenced the discharge process. The median survival after discharge was five days. When a rapid discharge was confirmed, the ambulance response time target was two hours.
- We were told that the SPCT had referrals for eleven patients in Chorley and South Ribble Hospital in September 2016.
- The introduction of the Electronic Palliative Care Coordination Systems (EPaCCS) improved communication between the GP, community staff and the hospital. The system allowed access for all healthcare services to electronic patient records. This meant that nurses and doctors did not rely on transfer of paper records between services before being able to treat the individual. The red flag system meant the SPCT were alerted when a patient on the EPaCCS was admitted.
- A ward manager at Chorley and South Ribble Hospital explained the rapid discharge process and stated that patients needing urgent discharge usually went home within 24 hours. The fastest patient discharge had been arranged within three hours.
- At weekends, individual assessments were made and decisions to discharge included the patient's condition and home situation. Family were made aware if equipment was not available until Monday and assurances were gained from the community teams before the patient was allowed to go. Ward link nurses updated the palliative care team to share experience, learn and improve on their return.

Learning from complaints and concerns

- The trust had a complaints policy and staff knew how to direct patients and carers to the Patient Advice Liaison Service if they could not resolve the issues personally.
- There were four complaints that involved patients seen by the end of life team between April and September 2016. The trust provided details of the complaints that involved patients who died in the trust between April and September 2016. The palliative care team were involved with the investigations and subsequent changes implemented.
- As a result of a complaint, the SPCT delivered a week of focussed training on one specific ward. The ward also implemented changes as a direct response and fed back to the family the improvements made.
- As a response to feedback from families, a monthly follow up clinic was developed to provide relatives the opportunity to ask questions and seek advice. Families were given the opportunity to meet the palliative care and bereavement team. This session was found to resolve any issues and communicate with family before issues became complaints.

Are end of life care services well-led?

Good

At the previous inspection in July 2014 we rated well led as good. Following this inspection we have maintained this rating because:

- There was a clear vision in place with excellent monitoring of performance against the vision, which adhered to local and national standards. Action plans and recommendations were in place to achieve the desired outcomes.
- There were plans in place to expand the medical and nursing staff we spoke with in the hospital valued the work of the SPCT and were positive about the end of life provision.

End of life care

- All staff we spoke with felt respected and valued in the workplace by their managers. Managers were proud of the work of their teams. Staff told us they felt involved in the decision making process within their areas and their views were important.

However;

- The individualised plan of care document had been in place less than a month at the time of inspection and would need further training and awareness to ensure its continued use.
- Since the Care of the Dying in Hospital audit the trust had recruited a trust lay board member with responsibility for end of life care. However, there was a lack of clarity among the staff as to who the lead was.
- There were no risks associated with the end of life service on the trust risk register. Staff knew and managed risks locally but there was no visibility to management or the board.

Vision and strategy for this service

- The trust had an integral role in the end of life care strategy group for Greater Preston, Chorley and South Ribble. Partners recognised the value of integrated health and social care and providing a whole-systems approach. A strategy had been developed with clear targets, visions and goals. Measured outcomes were set.
- The strategic clinical network had an End of Life Care Advisory group. All specialist palliative care hospital services and hospices across Lancashire and South Cumbria were represented on the group. Examples of activity included development of prescribing guidelines and agreement on referral processes across the network. Sub groups concentrated on developing education and training recommendations.
- Since the National care of the Dying audit in March 2016, the trust had given responsibility for EOLC to an existing non-executive director. However, there was a lack of clarity during the inspection among staff as to who the lead was. The trust confirmed the position after the inspection.

Governance, risk management and quality measurement

- The progress of the end of life strategic action plan was monitored, for example, the end of life dashboard examined staff education and preferred place of death targets. Regular meetings took place at board and department level to discuss progress.
- Staff were clear about their role within the trust and how the team integrated within wards and departments. Staff had individual roles in the provision of end of life services.
- The palliative care team was proactive in monitoring incidents, audits, complaints and projects that involved patients at the end of life. Meetings took place with other staff groups at ward, department and divisional level.
- We were informed that the end of life care services had no risks listed on either a local or trust wide risk register. However, staff had an awareness of weaknesses and challenges of the service and issues were being addressed, for example, increasing staffing numbers to provide a seven-day service.
- The palliative care team had their own monthly team meetings and included governance as a regular agenda item. Quality and safety issues were discussed.

Leadership of service

- The Medical Director and Operations Director were responsible for end of life representation at board level. There were regular monthly meetings of the mortality/ end of life board team where assurances were gained against objectives and national standards. The new non-executive director had attended one meeting as end of life representative at the time of the inspection.
- According to staff, the palliative care lead employed by the trust was visible, approachable and passionate about providing the best end of life care possible. Challenges to the service were understood and steps were taken to improve.
- We saw positive local leadership within the specialist palliative care team and ward staff appreciated the supportive relationships within the team.
- The mortuary team had excellent local leadership. However, we saw an incident during the inspection that

resulted from poor communication with ward staff. Mortuary staff told us this was not an isolated problem and felt that senior management were not aware of operational problems.

Culture within the service

- Staff across the end of life care service reported they felt they had a valuable role within the trust. Staff were passionate and conscientious. Ward and discharge staff told us the team were respected and valued.
- SPCT staff understood duty of candour and were able to give examples of when open and honest conversations would be appropriate if things went wrong.

Public engagement

- A bereavement survey was conducted in 2015. Seventy-eight responses were received relating to deaths at the hospital between May and July 2015. The information was collated and shared with individual wards. Each ward addressed their feedback individually.
- The bereavement team facilitated help groups for family of deceased adults and children to support them emotionally and practically to manage their loss.
- The chaplaincy service had a visible presence on the wards and were able to comfort patients and family sensitively taking account of cultural beliefs and facilitating spiritual wishes of other faiths.
- The trust palliative care staff participated in educational events held at the local hospice that were available to the general public but aimed at anyone who provided end of life care.
- The Macmillan cancer information and support service team were based in the Rosemere cancer centre in the hospital outpatients department. The staff provided a range of information to the public on all aspects of living with cancer.

Staff engagement

- The Specialist Palliative Care team had developed a more proactive integrated working model with ward teams to facilitate early referrals, improve continuity of care and enhance advice and education opportunities. The team routinely attended surgeon of the week meetings, oncology board rounds and lung ward rounds. Staff attended Medical assessment unit (MAU), Acute Oncology and the Respiratory wards Gold Standards Framework (GSF) meetings.
- Staff participated in an annual appraisal. The rate for the SPCT was 62%, which was below the trust target of 85%. Staff told us they received support from their line managers and regular communication.
- The staff survey completed in 2015 was reported to the board in March 2016.The survey had a 35% response rate from staff. An analysis of the responses was performed and an action plan developed. In February 2016, the trust arranged three 'Big Conversation' events to investigate the top three positive and negative themes and what would make a difference to staff. The result was a comprehensive staff engagement proposal for 2016/18.

Innovation, improvement and sustainability

- The Transform education project supported by the SPCT team worked to promote recognising end of life, advanced care planning and preferred place of care education. This included joint education events with the community and hospice teams.
- Collaborative working with services across Lancashire had improved knowledge of the challenges faced by EOLC teams and enabled the creation of shared documentation to streamline processes and improve access.
- Trust end of life documentation had been assessed and improved in line with National Institute for Health and Care Excellence (NICE) guidance and local feedback. New care plans, charts and intranet guidance were launched in August 2016. At the time of the inspection, we saw these documents in use including the new intentional rounding chart. The prescribing guidance was standardised across the Lancashire and South Cumbria network.
- To improve access to SPCT, a new directorate of palliative care was established in April 2016. The directorate moved out of oncology, where integration was firmly embedded into the division of medicine and improved networking and integration. As a result, a second hospital consultant post had been developed and went to advert in August 2016. The trust was also taking part in the Enhanced Supportive Care the Commissioning for Quality and Innovation (CQUIN) and two nursing posts and an administration post were approved.

End of life care

- The bereavement team were one of only ten hospitals in the UK to participate in the NHSBT Active eye retrieval scheme. The service was funded annually on completion of a number of key performance indicators.

Outpatients and diagnostic imaging

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

Information about the service

A range of outpatient services are provided by Lancashire teaching NHS Foundation Trust at the Royal Preston Hospital and the Chorley and South Ribble Hospital.

The Royal Preston Hospital offers a combination of consultant and nurse-led clinics for a full range of specialities, including: cardiology, respiratory, ear nose and throat (ENT), diabetic, orthopaedic and fracture clinic, ophthalmology, Rosemere cancer centre, renal dialysis unit, day treatment centre, clinical investigations unit, mobility rehabilitation services (SMRC) and therapy services. The hospital offers a comprehensive range of diagnostic and interventional radiography services to patients including: general x-ray, computerised tomography (CT) scans, magnetic resonance imaging (MRI), nuclear medicine and ultrasound.

An outsourced dispensing service supplies all outpatient medicines. There were two dispensaries on the Royal Preston hospital site one in the main outpatient area and another in the cancer centre. A number of outpatient appointments are also offered at other locations including the specialist mobility rehabilitation centre (SMRC) and at other provider locations in the region (which we were not included as part of this inspection).

Hospital episode statistics data (HES) March 2015 to February 2016 showed 610,732 outpatient appointments were offered across the trust. There were 408,999 appointments at the Royal Preston Hospital.

We visited the hospital as part of a comprehensive inspection of the trust between 27 and 29 September 2016 and we inspected a number of outpatient and diagnostic services including ear, nose and throat (ENT), fracture clinic, chest and heart clinics, SMRC, the Rosemere cancer centre, ophthalmology, physiological services, pathology, radiology and diagnostic imaging services.

During our inspection we spoke with 32 patients, eight relatives and 66 members of staff including volunteers, nurses, health care assistants, technical and clerical staff, doctors, physiotherapists and radiographers. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and we examined 18 individual care records. Outpatients and diagnostic imaging

Outpatients and diagnostic imaging

Summary of findings

At the previous inspection in July 2014 we rated this service overall as requires improvement. Following this inspection we have maintained the overall rating because:

- The outpatients and diagnostics service was predominantly managed through the diagnostics and support services division. However key outpatient departments such as orthopaedics and ophthalmology were under a separate management structure. The recent changes in the divisional structure had led to some lack of clarity in terms of performance and governance.
- At our last inspection we found staff had not received clinical supervision, as required by the hospital's own policy and procedures. At this inspection we found this was still the case. Some staff told us that they had regular morning briefings and managers were accessible but they had not received and the trust did not provide details of staff uptake of clinical supervision.
- At our last inspection we found concerns within the ophthalmology department; clinics were sometimes cancelled at short notice and frequently ran late. At this inspection we found there were still issues regarding medical staffing and access to services in ophthalmology. In Ophthalmology there had been follow- up capacity pressures which had led to service governance concerns. The service had reported two serious incidents related to delays in accessing care and treatment.
- The environment was very cramped and did not assist staff in meeting the needs of individuals by providing appropriate consultation areas.
- The trust performed worse than the England average for referral to treatment times for non-admitted referral to treatment pathways in October 2015 and remained below the average each month to June 2016. Of the 16 separate specialties reported nine were below the England average, the lowest scoring being neurosurgery at 71%.
- For incomplete pathways of the 16 separate specialties reported, nine were below the England average, the lowest scoring being plastic surgery at 75%.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was worse than the standard for three of the four most recent quarters.
- Although there was a clear process for reporting and investigating incidents, staff told us they had not received outcomes of incidents submitted. We found that improvements were required by the trust to ensure that staff received regular feedback on incidents.
- We found some areas did have significant vacancies such as radiology and ophthalmology. Overall staffing numbers and skill mix met the needs of the patients.
- Care provided was evidence based and followed national guidance. Patients were treated with dignity and respect by caring staff. Patients spoke positively about staff and felt they had been involved in decisions about their care.
- Across outpatients and imaging services we found there was good local leadership and staff were committed to meeting the needs of their patients. Overall staff worked well as a team and supported each other. However we noted the recent changes to the directorate structures had had an impact on frontline staff with some staff unsure about reporting structures.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

At the previous inspection in July 2014 we rated safe as requires improvement mainly due to issues with a move from paper to electronic records, we have maintained this rating following this inspection because:

- At our last inspection we found all records were in the process of being scanned onto an electronic system, which would, over time, reduce the need for physical case notes in clinic. However at this inspection we found a mixed approach to the use of the electronic system. Staff were unsure which teams were using the system and others thought it was still in the pilot phase. We found that clinics had a mix of electronic records with one paper sheet with essential information as part of the booking in process. Other patients had a full set of paper records. We were unable to identify an agreed approach to the use of either paper or electronic records.
- We were not assured that the trust had ensured sufficient numbers of staff attended appropriate training to support the safeguarding of patients in the service.
- We were not assured that adequate numbers of staff had attended and completed identified essential training.
- The lack of visibility in all areas of the cancer centre and the lack of clear communication with patients may impact on the ability of the service to manage a deteriorating patient.
- We noted the sickness rate for core therapy services was 15% for qualified outpatient nursing staff which was worse than the trust target of 4%.
- The environment in the general outpatient area was well maintained, although we found that some areas of outpatients were crowded and lacked an effective ventilation system. Senior managers acknowledged the aging estate and the lack of space in the outpatients and diagnostic services. Staff told us and we observed that it was not always possible to separate vulnerable patients to reduce the risk of infection for some specialities. All patients were in the same waiting area, including immunosuppressed cancer and transplant patients, renal patients, infective patients and patients attending hepatitis clinics. We found the chest clinic waiting area in particular very cramped with poor wheelchair access.

However;

- An allied health professional and nurse staffing review was underway to review the appropriate skill mix and staffing levels to provide appropriate service delivery.
- In the period 01/08/2015 to 31/07/2016, there had been one never event in the diagnostic services at the hospital to which the service had responded appropriately to learn from the incident and reduce the risk of recurrence.
- There were a number of medical staff vacancies throughout the service although they were managing the situation with staff working additional shifts. We found that the majority of clinics were covered by consultants and their medical teams. In dermatology the service was short one full time consultant from four. We also found shortages in Ophthalmology consultant staffing. We noted seven staff vacancies in nuclear medicine.

Incidents

- In the period 01/08/2015 to 31/07/2016, there had been one never event in the diagnostic services at the hospital. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. A patient attended interventional radiology for a left sided procedure but the procedure was carried out on the right side. There was found to be no harm to the patient. The incident had been fully investigated including simulation and an action plan had been put in place and implemented. Processes had been introduced for interventional staff to display any previous imaging on a monitor during procedures from the start of the procedure.
- There were two serious incidents reported in outpatients over the same period related to access to appointments. All incidents were investigated using a root cause analysis (RCA) approach and all documented high level action plans and evidence of shared learning. An investigation using a RCA approach was also conducted for all diagnostic incidents within the imaging department.

- Incidents were reported using an electronic reporting system. Staff could describe how to use the system and the types of things that would constitute an incident. Staff meetings or morning briefings were held locally in the majority of teams within the outpatients and diagnostics which were minuted and lessons learned discussions took place.
- Data provided by the trust showed incidents were reported internally and externally, as required for diagnostic services. The service presented a review of clinical incidents, trends and any supporting action plans at the imaging directorate clinical governance meetings. Mortality and morbidity meetings took place bi-monthly within the diagnostic imaging department governance and audit meetings.
- We noted that reported incidents were investigated by senior managers and themes and trends were discussed at the divisional governance meetings.
- The division of diagnostics and clinical support produced a Division Safety and Quality Report looking at themes and trends within the division. An incident data analysis showed from March 2012 to the June 2016, 11 patients had been harmed due to incidents relating to the Ophthalmology appointment system.
- In response to referral errors in Computerised Tomography clinicians had amended a checklist to include “hello can I check you are here today for x”.
- Staff in pathology told us a newly introduced technology had eradicated transcription errors from the system. This was confirmed through an ongoing audit to evaluate the introduction of the system which reported through the divisional governance meetings.
- The specialist mobility rehabilitation centre (SMRC) put in place lessons learned after a patient fall with protocols and action plans to prevent reoccurrence.
- However, some staff said they didn’t receive feedback. We spoke with a member of staff who was unaware of an incident in the department the week before our inspection when a patient had fallen and found to have a broken wrist. It is important that staff are aware of incidents and receive feedback to provide learning and prevent further reoccurrence.
- In the twelve month reporting period prior to our inspection there were 46 patient related radiation exposure dose incidents at Preston and seven at Chorley. There had also been three staff incidents, two of which related to members of staff failing to wear protective aprons and the third to a damaged protective apron. These numbers represented an increase in the frequency of incidents as compared to the previous year and a continuation of an upward trend. Staff felt that the increase was in part due to an improved reporting culture.
- We identified a risk on the trust wide risk register relating to the flexibility of the provision of renal appointments at another provider location with a possible impact on patients being lost to follow up by clinical staff in Lancashire Teaching Hospitals NHS Foundation trust. The medical director confirmed that this was now being addressed in partnership with the other provider to mitigate the risk and an action plan was in place to resolve the issues.
- Many staff across outpatients and diagnostic imaging did not recognise the “Duty of Candour” regulation but they could describe the principle of it and gave examples of how they had been open with patients. 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.

Cleanliness, infection control and hygiene

- Patients received care and treatment in visibly clean environments. Records indicated that outpatient areas, clinics and equipment were cleaned regularly. Cleaning schedules were in place and accurate records maintained. The service used “I am clean” stickers to identify equipment that had been cleaned.
- Staff followed good practice guidance in relation to the control and prevention of infection. We observed good hand washing and infection control practices throughout. This included the use of personal protective equipment where appropriate, e.g. disposable gloves. There was an ample supply of alcohol hand gel dispensers and hand washing facilities were readily available.
- There were trust-wide policies in place for infection control and hand hygiene which were seen to be in date at the time of the inspection. Staff were aware of them and showed us how they accessed trust policies from the intranet.

Outpatients and diagnostic imaging

- The service carried out internal audits and checks relating to infection prevention and control. Data provided by the trust showed these were in house checks and compliance was 100% in most areas.
- Staff told us they would see any infectious patient last on the list and carry out a deep clean after the treatment session.
- However staff told us and we observed that it was not always possible to separate vulnerable patients to reduce the risk of infection for some specialities. All patients were in the same waiting area, including immunosuppressed cancer and transplant patients, renal patients, infective patients and patients attending hepatitis clinics. The lack of adequate ventilation in waiting rooms could increase the risk of the spread of infection .
- The clean utility areas also served as weighing room, pre clerking room, computer room and housed the resuscitation trolley.

Environment and equipment

- The environment in the general outpatient area was well maintained, although we found that some areas of outpatients were crowded and lacked an effective ventilation system. Senior managers acknowledged the aging estate and the lack of space in the outpatients and diagnostic services. We found the chest clinic waiting area in particular very cramped with poor wheelchair access.
- Throughout the outpatient area we noted that the corridors were busy and it was difficult to manoeuvre wheelchairs in some of the secondary waiting areas. The resuscitation trolley was also in one link corridor for access but also made the area very cramped.
- We found during busy periods the queue in the main reception area blocked access to the other outpatient areas. Each clinic room we looked at was cluttered and did not have easily accessible couches for people with mobility issues. We also noted that the walls between each clinic room were very thin and conversation could be overheard from adjacent rooms.
- Resuscitation trolleys were located in or close to each outpatient area and regularly checked and maintained. The heart and chest clinic shared a resuscitation trolley with the Genital Urology medicine clinic. The clinical investigation clinic had its own resuscitation trolley which was checked daily. We found that none of the trolleys were locked in line with the rest of the hospital. We noted that saline bags were accessible within the trolleys. This was reported to the trust at the time of the inspection and appropriate actions were taken to secure these.
- The emergency resuscitation trolleys we reviewed were visibly clean and weekly checklists completed. Oxygen, suction and defibrillator checks were performed daily.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment. All equipment we looked at was in date with portable appliance testing (PAT). PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.
- Clear signage and safety warning lights were in place in the x-ray departments to warn people about potential radiation exposure.
- Occupational exposure to radiation was monitored for radiology staff. This ensured that the amount of radiation staff were exposed to as part of their work was checked.
- The specialist mobility rehabilitation centre (SMRC) had been funded for a state of the art gym area funded for the use military veterans which was positively received by the staff and patients. An outdoor test track was also in use for patients to test out their mobility on different terrains and obstacles in a safe environment.
- The SMRC also had a separate children's play room with soft play and child friendly equipment.
- The unit had sufficient stock of dialysis equipment / pumps to ensure faulty equipment could be replaced as and when needed.

Medicines

- The hospital used the services of a local pharmacy company to dispense all hospital prescriptions. Data showed outpatient medicines were delivered within the 20 minutes target for the twelve month period prior to our inspection.
- The service monitored all errors on written prescriptions, which were discussed at monthly intervention meetings with the trust.
- Medicines in outpatients and radiology were stored securely in locked cupboards or refrigerators, as appropriate, and in line with legislation.

- In the renal dialysis unit controlled drug cabinets were secure and log books double signed. There was support from a pharmacy technician available during the week to replenish stocks.
- Medication fridge temperatures were checked daily and items were in date. It was noted the renal unit used a different template of temperature recording form to the rest of the hospital.
- Patient group directions (PGDs) were in place for a limited number of drugs including specific instructions for administering and staff using PGD's were competency assessed annually.
- Prescription pads were stored securely and their usage was tracked.
- Some staff within the outpatient services such as dermatology and chest clinic were registered nurse prescribers. Nurse prescribers are specially trained nurses allowed to prescribe any licensed and unlicensed drugs within their clinical competence.

Records

- At our last inspection we found all records were in the process of being scanned onto an electronic system, which would, over time, reduce the need for physical case notes in clinic. However at this inspection we found a mixed approach to the use of the electronic system. Staff were unsure which teams were using the system and others thought it was still in the pilot phase. We found that clinics had a mix of electronic records with one paper sheet with essential information as part of the booking in process .Other patients had a full set of paper records. We were unable to identify an agreed approach to the use of either paper of electronic records.
- We looked at the systems and processes in place for managing patients' records and ensuring that medical staff had timely access to patient information and test results. There was a clear system in place to support this. If patient records were unavailable a temporary record was prepared, this meant that clinic appointments were not cancelled due to missing records. As part of this inspection we looked at 18 patient care records and saw records were well maintained and updated at timely intervals. Each professional had recorded their entries appropriately; documentation was accurate, complete, legible and up to date. There was a plan of care for each patient. Consent was documented and care plans present as appropriate.

Safeguarding

- Trust-wide policies and procedures were in place, which were accessible to staff electronically for safeguarding vulnerable adults and children.
- Data provided by the trust showed only medical staff had completed training for safeguarding adults (level two and three) in diagnostic services whilst other staff had achieved 44% and 51% compliance. In outpatients only 49% of medical staff had completed training in safeguarding adults, level 2 and 54% for level three. Other staff had completed 52% and 55% for safeguarding levels two and three which was below the trust target of 75%. We were not assured that the trust had ensured sufficient numbers of staff attended appropriate training to support the safeguarding of patients in the service.
- However we found staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults, and were aware of the process for reporting safeguarding concerns. Staff told us they felt confident to raise concerns and make safeguarding referrals, and felt well supported to do this.
- Staff told us they had access to a a trust-wide safeguarding team for advice during normal working hours.

Mandatory training

- The trust had a core mandatory training programme on a rolling basis such as health and safety and fire. In addition other training was compulsory such as resuscitation. Training uptake was reported and monitored across the division for diagnostics and theatre and outpatients. However we were unable to obtain a breakdown of training for the individual outpatient areas such as ophthalmology or the Specialist Mobility Rehabilitation centre (SMRC).
- Information provided by the trust showed 84% compliance rates with mandatory training for the division of diagnostics and clinical support division overall which was above the trust target of 80%. The diagnostic services had a compliance total of 88% for mandatory training. It was noted that for nursing staff within the theatre and outpatient business unit the

service was just below the trust target of 80% with 79% of staff having completed their mandatory training. Staff told us that they were encouraged complete their mandatory training, however this was difficult due to workload.

- The data showed 100% compliance for medical staff resuscitation training within the division. Data showed that training rates for all other staff groups in the different elements of resuscitation ranged from 65% to 90% against a trust target of 80%.
- In diagnostic services we found the average compliance rates for clinical movement of patients was 54% and 59% for outpatient clinical staff below a trust target of 60%. We were not assured that the service had in place adequate numbers of staff who had completed identified essential training.

Assessing and responding to patient risk

- The Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results to measure and monitor local improvement. The safety thermometer includes a function for merging patient safety data across all the teams and wards within the trust. The outpatients and diagnostics service was not using the safety thermometer.
- Staff were able to describe the procedure if a patient became unwell in their department. We witnessed a member of the public collapse in the Rosemere cancer centre. We noted that there appeared to be a delay in staff attending to the individual. We reported this to senior managers and discussed this with staff in the centre. Staff outlined the reasons why they could not leave a patient undergoing radiotherapy to attend the individual who had collapsed. Senior staff told us they had reviewed their processes since the incident and acknowledged the lack of visibility in that part of the centre which was being addressed as part of the review of the incident. Patients also told us they could be left unattended a long time in the centre if a clinic overran. The lack of visibility in all areas of the centre and the lack of clear communication with patients may impact on the ability of the service to manage a deteriorating patient.
- We observed that a patient had been transferred to the Rosemere centre from another provider for therapy. The records showed that no risk assessment had been completed on the individual during their time in the unit although staff had asked about nutritional needs. We reported this to senior staff who informed us the patient would normally have access to specialist mattresses if required. At our unannounced visit the case had been reviewed and initial remedial action was that any patients that attend the service requiring nursing care were to be transferred to the oncology in patients ward so they can receive appropriate treatment whilst they waited for outpatient treatment. Plans were also in place to develop a pre-information/ initial assessment document to identify patients with specific needs who could then wait in the oncology ward.
- Clear signs were in place informing patients and staff about areas where radiation exposure took place.
- Imaging requests for inpatients were completed electronically. Requests from general practitioners were a combination of electronic and paper referrals and any paper requests required a GP stamp to confirm the referrer for the procedure to be completed.
- Forms were completed for women of child bearing age before exposure to radiation in case of pregnancy. Completed forms were signed by the patient and then entered into the medical records.
- Safety procedures were observed in radiology to ensure the right patient got the right scan at the right time. Staff in radiology were observed obtaining name, address and date of birth of patients on arrival which related to a requirement of the Ionising (Medical Exposure) Regulations (IR (ME) R 2000).
- Staff in interventional radiography used the World Health Organisation (WHO) Surgical Safety Checklist. This aimed to reduce harm during operative procedures by using consistently applied evidence-based practice and safety checks to all patients.
- Radiation Protection Supervisors were appointed in each clinical area within the diagnostic and imaging departments and staff could identify these personnel.

Nursing staffing

- Outpatient clinics were staffed by a combination of specialist and outpatient nurses and staff worked across both the Preston and Chorley and South Ribble sites.
- A review of outpatients staffing had been commenced but the outcome was not yet finalised and was dependent upon the ongoing outpatients service review. Non ward based departments were also having

staffing reviews as part of the wider nursing and midwifery staffing review process. Senior managers told us the service was out to consultation about changes to working practices.

- Staff told us that the number of extra waiting list initiative clinics had added extra pressure to nursing staff in outpatients with many working extra hours on a good will basis.
- The service did not use agency staff but relied on extra band three staff and the use of substantive staff working extra hours.
- The trusts 2015/16 annualised sickness absence rate was 5.1% which worse than the England average of 4.5%. We asked the trust for the specific sickness data for outpatients and diagnostic imaging. The 2015/16 annualised sickness absence rate for qualified nurses and nursing support staff in Royal Preston hospital outpatients were 15.7% and 6.1% respectively. However we were unable to review detailed sickness rates for all areas of the service.

Allied Health Professionals

- Radiographers provided a 24 hour seven day service. The trust had seven vacancies at the time of our inspection, however recruitment was in progress.
- An allied health professional staffing review was underway to review the appropriate skill mix and staffing levels to provide appropriate service delivery. We noted the sickness rate for core therapy services was 2.4%.

Medical staffing

- The radiology department was staffed by consultant radiologists. The Imaging Directorate provided 24/7 cover for both hospital sites. The core hours of work for medical staff were 9am to 5pm Monday to Friday. From 5pm to midnight on-call support was provided for emergencies by a Radiology Registrar who was first on-call and a Consultant Radiologist who was second on-call.
- From midnight CT and MRI scans for cord compressions were covered by an external provider.
- Overall there was a sufficient number of medical staff to support outpatient services. We found that the majority of clinics were covered by consultants and their medical teams. However we found in dermatology the service was short one full time consultant from four. We also found shortages in Ophthalmology consultant staffing. There were currently two full time Ophthalmology Consultants and one full time Specialty doctor vacancies. As a result the service was reliant upon locum agency staff. Senior managers told us the service continued to proactively recruit to vacant posts however this had proven difficult due to a national shortage of Ophthalmology specialists.
- There were seven staff vacancies in nuclear medicine but managers told us this was being managed through extra clinics and staff covering extra hours. We were not assured that this was sustainable in the longer term.
- In the renal dialysis unit medical staffing was covered with a consultant of the week, supported by registrar medical on-call rotas (registrars from inpatient ward area). There was sufficient medical support in the area.
- In the Clinical investigations unit (CIU) infusion area treatment was overseen by a consultant and patients reviewed three times weekly. Antibiotic infusion was overseen by a consultant microbiologist. Major incident awareness and training
- There was a clear policy of action to be taken if the hospital was involved in a major incident. Staff members were aware of the policy and how to locate it on the trusts intranet.
- There were business continuity plans in place to ensure the delivery of the service was maintained.
- Within the nuclear medicine department actions in the event of a major spill incident formed part of the local rules.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not rate Outpatients and diagnostic imaging services. Our findings were:

- Patients who attended outpatients and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance.
- The radiology and diagnostic service was provided seven days a week.
- Staff worked together in a multi-disciplinary environment to meet patients' needs. Specialist nurses were available if required.

Outpatients and diagnostic imaging

- Information relating to a patient's health and treatment was available from relevant sources before a clinic appointment and staff had access to previous x-ray images. Information was shared with the patient's GP following hospital attendance to ensure continuity of care.
- Staff were competent to perform their roles and were supported by the trust to develop.
- Follow up to new appointment rates at both sites were slightly worse than the England average between March 2015 and February 2016. Rates were around 3% on average.
- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).

However;

- At our last inspection staff had not received clinical supervision, as required by the hospital's own policy and procedures. At this inspection we found this was still the case. Some staff told us that they had regular morning briefings and managers were accessible but they had not received and the trust did not provide details of staff uptake of clinical supervision.
- The head and neck service had been the subject of an external review which had raised concerns about teamwork and clinical effectiveness in the outpatient multidisciplinary team (MDT). The report produced recommendations from which an action plan had been formulated. We raised this with the trust senior executives and further meetings were planned for the autumn to seek assurance that improvements had been sustained in line with the action plan. We were not provided with any evidence of any completed actions or changes in team working at the time of our inspection.

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).
- Audit and staff meetings were held in diagnostics and imaging, dermatology and SMRC to share information and promote shared learning.
- Audits of compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were completed and Radiation Safety Committee meetings were held twice a year to monitor radiation safety throughout the trust.
- Diagnostic reference levels (DRL's) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective, but safe scan for each body part.
- We reviewed minutes from Radiation Protection Supervisor meetings which reviewed radiation incidents and issues and observed an action plan to maintain quality assurance. Audit and staff meetings were held in radiology to share information and promote shared learning.
- The pathology service had achieved national accreditation.
- SMRC had introduced protocols in the management of diabetes and low blood sugars and a review of this practice was ongoing.
- The SMRC followed the Evidence Based Clinical Guidelines for the Physiotherapy Management of Adults with Lower Limb Prostheses.
- The service had implemented a pathway for the management of skin cancer patients referred from dermatology to oncology who had been deemed unsuitable for radiotherapy to ensure care was provided in a timely manner by the most appropriate service.
- The diagnostic imaging service took part in the "Imaging Services Accreditation Scheme" (ISAS) to ensure they met quality standards.
- The physiological measurement services participated in the "Improving Quality in Physiological Services" (IQIPS) accreditation scheme.
- Clinical audits were in place in Speech and language therapy and musculoskeletal physiotherapy services looking at outcomes of therapy intervention and the quality of service delivery.

Pain relief

- There was a newly appointed clinical lead for the pain clinic. Patients could be referred to the pain management clinic by their consultant.

- Patients had access to pain relief as required. This could be prescribed within the outpatients department and subsequently dispensed by the pharmacy department, which was located within the outpatient's reception area.
- Staff told us they followed the national guidance on "oral analgesia in the management of acute pain in adults".

Nutrition and hydration

- Refreshments were available in the main entrance to the hospital as well as a restaurant on site. Staff in the ophthalmology clinic and discharge lounge provided drinks for patients.
- The service was aware of the needs of diabetic patients and we observed the use of a drinks trolley for patients in the eye clinic.

Patient outcomes

- The SMRC followed the British Association of Chartered Physiotherapists in Amputee Rehabilitation (BACPAR) guidelines which looked at outcome measures. The SMRC was performing better than the national average.
- The SMRC had introduced supervised exercise therapy for peripheral vascular disease (PVS) to improve the outcomes for patients. The service was also implementing protocols for early rehabilitation and continuity of care for patients with PVS to improve function and quality of life.
- Follow up to new appointment rates at both sites were slightly higher (worse) than the England average between March 2015 and February 2016. Rates were around 3% on average, putting the trust in the top quartile in England for follow up rates although rates were similar to the England average. This meant that patients may be returning for appointments more frequently which may impact on the effectiveness of treatment. This information was trust-wide across outpatient and outpatient and diagnostic services and not specific to the Royal Preston Hospital. We noted follow up rates were higher (worse) than the trust average for ophthalmology and ENT.
- Data provided by the trust showed that Dermatology outcomes were better than the national average.

Competent staff

- At our last inspection we found staff had not received clinical supervision, as required by the hospital's own policy and procedures. At this inspection we found this was still the case. Some staff told us that they had regular morning briefings and managers were accessible but they had not received and the trust did not provide details of staff uptake of clinical supervision.
- Competency assessments were in place throughout outpatients and imaging services for example in the main outpatient clinic, Ear, Nose and Throat (ENT) clinic and dermatology. Staff were able to assess their ability and review the effectiveness of the guidance provided.
- Specialist nurses were in post and provided a wide range of nurse-led clinics including dermatology, ENT and foot clinics. The specialist nurses and therapists had also completed extended prescribing courses to expand their skills and improve the quality of service delivery.
- New staff were required to complete a full day corporate induction and a local induction before undertaking their role.
- The Trust had continued to take measures to ensure that all laser users and related staff had received appropriate training. Staff had recently attended laser safety, core-of-knowledge and laser protection supervisor training.
- Staff told us they had received annual appraisals known as personal development reviews. Records showed that personal development reviews had taken place and that staff were supported with their development and educational needs.
- We saw staff had access to training specific to their clinical area of practice. Staff told us they had access to appropriate and job-specific training opportunities. In radiology all staff training and student supervision was in place, up to date and appropriate.

Multidisciplinary working

- The head and neck service had been the subject of an external review which had raised concerns about teamwork and clinical effectiveness in the outpatient multidisciplinary team (MDT). The report produced recommendations from which an action plan had been formulated. We raised this with the trust senior executives and further meetings were planned for the autumn to seek assurance that improvements had been sustained in line with the action plan. We were not provided with any evidence of any completed actions or changes in team working at the time of our inspection.

Outpatients and diagnostic imaging

The diagnostic imaging and outpatients departments were staffed by a range of professionals working together as a multi-disciplinary team to provide a comprehensive service to patients.

- Specialist nurses were in post and provided a wide range of nurse-led clinics including ENT and Dermatology.
- Monthly team meetings were held within the therapy department involving all disciplines to exchange information.

Seven-day services

- At weekends from 9am to midnight on-call support was provided for emergencies by a Radiology Registrar who was first on-call and a Consultant Radiologist who was second on-call. From midnight CT and MRI scans for cord compressions are covered by an external supplier.
- Pathology services offered a seven day service.
- Alongside the general radiology on-call rota there was a neuro-radiology on-call service 24/7 and an interventional radiology on-call service which operated 24/7 cover. This had commenced in September 2016.
- Outpatient services had introduced a range of waiting list initiative clinics on Saturdays.
- The clinical investigations unit (CIU) infusion area ran an outpatient service seven days a week, 8am-5pm Mon-Thurs, 8am – 6pm Friday and 8.30-2.30pm on weekends (including bank holidays)

Access to information

- The radiology department used a nationally recognised system to report and store patient images.
- The pathology service had introduced new technology which had improved access to investigation results.
- Staff told us that appointments were not cancelled due to unavailability of records, as a temporary record was raised that included new patient referral letters. Previous investigation results and letters were available electronically for patients attending a follow up appointment.
- Regular monthly audits were undertaken to monitor availability of records and reported to the trust board. Data provided by the trust showed for the period January 2015 –December 2015 showed 99% availability of notes in clinics.
- Staff told us some information, such as test results and x-rays, were accessed electronically and computers were available in all clinics.
- Staff were able to access information such as policies and procedures from the trust's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients and diagnostic imaging worked on the principle of implied consent. If written consent was required for more complex procedures this was obtained in outpatients' clinic by medical staff or nurses who had received additional training.
- Before having a procedure undertaken patients' consent was obtained verbally and noted in their records. For biopsies or more invasive tests, consent for procedures was formally documented using consent forms. The risks and benefits of treatment were discussed with the patient before starting the procedure.
- Staff were provided with training and guidance on the Mental Capacity Act 2005. Staff were aware of the requirements to ensure that people were treated appropriately.

Are outpatient and diagnostic imaging services caring?

Good

At the previous inspection in July 2014 we rated caring as good, we have maintained this rating following this inspection because:

- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff. Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes.
- The trust had a number of clinical nurse specialists and lead nurses available to support patients in managing their condition.
- There was access to volunteers and local support groups such as a cancer charity which offered both practical advice and emotional support to both patients and carers.
- The Specialist Mobility Rehabilitation Service (SMRC) held parties twice a year which offered social and peer support for patients and their families. Staff ran these voluntarily.

However;

Outpatients and diagnostic imaging

- Some patients told us that they had been left waiting a long time for their appointment and had not been kept informed about what was happening.
- We found the environment was rather crowded and the lack of privacy made it difficult for patients to have a private conversation about their medical condition or treatment.

Compassionate care

- We found individual examples of compassionate care within outpatients and diagnostic services. We observed staff dealing with patients in a very supportive manner, especially in the chemotherapy day unit.
- Patients and relatives told us that staff introduced themselves and they were treated with kindness and compassion. Some patients told us that the outpatient department could be very busy and rather overcrowded which made it difficult to have a private conversation about their medical condition.
- We witnessed reception and nursing staff being polite and helpful both in person and during telephone contacts.
- The main x-ray department had signs asking patients to respect patient confidentiality and wait to be called forward.
- The radiology department had provided an additional gown as a dressing gown worn to cover people's dignity whilst having an x-ray or ultrasound.
- The trust had a chaperone policy and signs were visible throughout the service informing patients how to request a chaperone.
- We received 27 feedback comments for the Specialist Mobility Rehabilitation Service (SMRC) with only three negative comments.
- The NHS Friends and Family Test which assesses whether patients would recommend a service to their friends and family showed that from June 2016 to August , 88% of patients on average were likely or extremely likely to recommend the service with an average response rate of 12%.

Understanding and involvement of patients and those close to them

- We spoke with patients and those close to them about the care and treatment they received in outpatient services. Each patient we spoke with was clear about what appointment they were attending for, what they were to expect and who they were going to see. Patients and relatives said they felt involved in their care and were able to make informed decisions. Patients we spoke with said they had received good information about their condition and treatment.
- Patients told us they understood when they would receive their test results and next appointment and how they could contact the service if needed.
- Patients were informed following diagnostic investigations when they should contact their GP for the results.
- Team leaders within the chemotherapy day unit interacted appropriately and staff were very professional and courteous.

Emotional support

- Patients told us they were always involved in discussions about their treatment.
- The trust had a number of clinical nurse specialists and lead nurses available to support and reassure patients regarding the management of their condition.
- There was access to volunteers and local support groups such as a cancer charity which offered both practical advice and emotional support to both patients and carers.
- The Specialist Mobility Rehabilitation Service (SMRC) held parties twice a year which offered social and peer support for patients and their families. Staff ran these voluntarily.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

At the previous inspection in July 2014 we rated responsive as requires improvement mainly due to the cancellation of clinics at short notice. We have maintained this rating following this inspection because;

- The trust performed worse than the England average for referral to treatment times for non-admitted referral to treatment pathways in October 2015 and remained below the average each month to June 2016. Non-admitted pathways means those patients whose treatment started during the month and did not involve admission to hospital. This information was trust-wide and not specific to Royal Preston Hospital.

Outpatients and diagnostic imaging

- Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month. Of the 16 separate specialties reported, nine were below the England average.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was worse than the standard for three of the four most recent quarters. Senior managers acknowledged an increased demand within outpatient services. In Ophthalmology there had been follow-up capacity pressures which had led to service governance concerns. The capacity problems within Ophthalmology had resulted in a number of patients waiting longer than advised for review in clinic.
- Data provided by the trust showed only 65% of patients were seen within 30 minutes of their appointment time compared with the trust average of 91%. This information was trust-wide and not specific to Royal Preston Hospital. Patients in ophthalmology were waiting a significantly longer time in clinic than all the other trust outpatient services.
- It was reported by patients that poor signage made navigating to departments difficult and some told us this made them anxious.

However;

- At our last inspection we told the trust to prevent the cancellation of outpatient clinics at short notice and ensure that clinics ran to time. Data provided by the trust showed an improvement since our last inspection.
- The percentage of people seen by a specialist within two weeks of urgent GP referral was above (better than) the national standard in the last four quarters prior to our inspection. The service provided a number of rapid access clinics such as chest pain, emergency eye clinic and an ENT neck clinic.
- Access to interpreter services could be arranged by telephone for those patients whose first language was not English and provision was made for bariatric patients.
- Within the outpatient areas there was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. Staff confirmed the leaflets could be ordered in other languages or alternative formats if required.
- Laboratory reporting times were in line with the nationally recommended turnaround time target of 90% of cases reported in 10 working days.

Service planning and delivery to meet the needs of local people

- At our last inspection patients who drove themselves to their appointment told us they found car parking difficult because the demand for spaces was high, and they often had a long walk to get to the department. Some people told us they had problems finding a department because of poor signage which made them feel anxious.
- At this inspection we found that demands on car parking were still evident. Orientation around the outpatient areas was not easy. There was no clear signage to help patients with reduced capacity identify the individual clinics.
- We observed signposting throughout the hospital to the diagnostic imaging departments. The main x-ray department and reception desk had signs asking patients to respect patient confidentiality and wait to be called forward. Patients told us they received instructions with their appointment letters and were given written information, as needed.
- Waiting areas did not always have sufficient seating available and we found some toilet signs were not compliant with dementia friendly guidelines.
- The outpatient department was fragmented throughout the hospital site. Managers told us patients came into main reception but then got lost. In response to this the services had introduced a “meet and greet” to help patients find the correct department.
- Additional clinics were being held in the evenings or at weekends to reduce waiting times for patients.

Access and flow

- The outpatients department was able to access magnetic resonance imaging (MRI) scanning. An MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. We were informed there were no concerns within the imaging department and MRI scans were conducted within four to six weeks.
- Diagnostic imaging waiting times (percentage over six weeks) were better than the England average between July 2015 and May 2016.

Outpatients and diagnostic imaging

- The two week wait performance was better than the national standard in the last four quarters prior to our inspection. The service provided a number of rapid access clinics such as chest pain, emergency eye clinic and ENT to enable patients to access an appointment quickly.
- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was better than the standard for the last three quarters of 2015/16 but was worse than the standard in the first quarter of 2016.
- The trust performed worse than the England average for referral to treatment times for non-admitted referral to treatment pathways in October 2015 and remained below the average each month to June 2016.Non-admitted pathways means those patients whose treatment started during the month and did not involve admission to hospital. This information was trust-wide and not specific to Royal Preston Hospital. Of the 16 separate specialties reported nine were below the England average, the lowest scoring being neurosurgery at 71%.
- Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month. For incomplete pathways, referral to treatment rates were similar to the standard between July and November 2015 before falling below the standard and continuing to fall gradually each month until June 2016. Of the 16 separate specialties reported, nine were below the England average, the lowest scoring being plastic surgery at 75%.This information was trust-wide and not specific to Royal Preston Hospital
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was worse than the standard for three of the four most recent quarters.
- Each performance business manager was able to request extra clinics as part of waiting list initiatives. A weekly performance managers meeting was held to review all waiting times. As of 27 September 2016 2375 patients were waiting for a new first appointment with 1633 patients waiting over six weeks for a neurology appointment. We discussed the service performance with senior managers. They acknowledged an increased demand within outpatient services. In Ophthalmology there had been follow- up capacity pressures which had led to service governance concerns. Ophthalmology had had a full service review and redesign action plan was in place. The service had reported two serious incidents related to delays in accessing care and treatment. The capacity problems within Ophthalmology had resulted in a number of patients waiting longer than advised for reviews in clinic. We were told that there was no booking strategy and the current access policy was due for review in December 2016. The lack of clear management approach to managing appointments may impact on the service ability to manage its risk demand management and referral pathways.
- Data from the trust showed that in patient radiology examinations were reported on the same day. There was a two week turnaround for routine cases. Reports for CT trauma were completed within an hour.
- Information from the trust showed that laboratory reporting times were in line with the nationally recommended turnaround time.
- The trust had a number of patients who failed to attend for their appointments. The 'did not attend' (DNA) rates were similar to the England average at all sites within the trust.
- At our last inspection we told the trust to prevent the cancellation of outpatient clinics at short notice and ensure that clinics run to time. Data provided by the trust showed an improvement since our last inspection. Between April 2016 and July 2016 the percentage of clinics cancelled within six weeks averaged 2.5% with one exception of 11% in April. Clinics cancelled over six weeks ranged between 9% and 4%. The main reasons for cancellation were annual leave, study leave and sickness. This information was trust-wide and not specific to Royal Preston Hospital.
- In the SMRC the percentage of appointments commencing within 30 minutes or less of the scheduled appointment start ranged from 91.83 % for the main appointments and 94% for physiotherapy appointment for the period June-August 2016. The average figure for the trust as a whole was 91% of patients were seen within 30 minutes of their appointment time. Data provided by the trust showed 90% were seen in ENT and only 65% of patients were seen within 30 minutes of their appointment time. The trust average for waiting times over 60 minutes was 1.5%. However we noted the figure was as low as 19% in ophthalmology. This meant patients in ophthalmology were waiting a significantly longer time in clinic than all the other trust outpatient services.
- The SMRC and External Wheelchair Clinic waiting times targets were 12 weeks from the date of the clinical

referral to when the patients are seen at clinic. Data provided by the trust showed that as of August 2016 there were 192 patients awaiting assessment of which 15 patients were out of the 12 week indicative/target level (7.8%).

- The service was meeting the local quality commissioning target in SMRC was set as 100% of patients to be seen within 28 days or less for prosthetics.
- Managers told us orthotic waiting times had improved from six months in January to three months longest wait in August.
- We found that a nurse led foot clinic enabled patients to be discharged in line with set protocols. However we noted that there was no cover for annual leave which meant that the clinic didn't take place when the member of staff was absent and pateints did not have access to the clinic.
- We visited the Clinical Investigations Unit (CIU) which had two parts (Neurosurgery was managed by medicine) and a CIU infusion area which was an outpatient service. The purpose of the unit was admission avoidance or allowed patients to be treated in the unit instead of an inpatient stay. It allowed patients to come for IV antibiotic infusion, blood transfusion or iron infusion. The service had approximately 30 patients admitted per day with ten chairs and two bed spaces.
- We found the Day Treatment Centre Clinics generally ran on time. The service allowed 30 minute slots for new patients and 15 minutes for follow ups. The clinic overbooked clinics by one or two patients to account for any cancellations / DNA. Waiting times were written on white boards in the outpatient areas, monitored and updated every 15 to 30 minutes. The trust average for patients waiting over 30 minutes to see a clinician was 9%.
- DNA rates in the CIU clinic were not high. Where patients did not attend they were allowed two opportunities to attend with letters sent to their GP. If they failed to attend a third time they were taken off the appointment list unless there were special circumstances.

Meeting people's individual needs

- Patients had a choice of appointments and additional clinics were held in the evenings or at weekends to reduce waiting times.
- We observed in the main outpatient area the proximity of other patients waiting to the person booking in meant that patient confidentiality could not always be assured.
- Staff tried to meet the individual needs of patients. We observed that one patient who attended clinic had been offered an appointment on the same day as having a cast brace fitted. This meant they did not have to re attend for a separate appointment. Other patients had arrived on the wrong day for an x-ray but had been seen by the department.
- Translation services and interpreters were available to support patients whose first language was not English. If staff were alerted to a patient's requirements, face to face translators could be booked in advance; on the day of our visit we observed that an interpreter had arrived to support a patient at their appointment.
- Staff acknowledged the service had been limited for people with hearing impairment but the trust was piloting using skype for sign language. In the outpatient and imaging services sign language interpreters could be 'requested' in advance for patients.
- We saw that nursing and therapy staff liaised with other agencies and families and carers to maintain daily routines and support patients in vulnerable circumstances. However, we noted that there was no system in place to alert the staff in advance to help meet any specific needs such as people living with dementia or learning disabilities.
- Staff could not confirm what information was available for people living with dementia and learning disabilities. There was a limited access to information for patients who had a visual impairment.
- There was a range of information leaflets in clinical areas on topics such as tests and screening, health promotion and other sources of support. However they were not available for patients whose first language was not English. Staff confirmed the leaflets could be ordered in other languages or alternative formats if required.
- Staff treated patients in a discreet and dignified manner within the limits of the environment. Privacy and dignity were maintained in radiology despite lack of space in some areas. In imaging we noted a sign requesting patients not to use social media or take photographs to respect individual patients' privacy and dignity.
- We found the limited space and the design of the outpatient and diagnostic areas meant that it was hard

to maintain privacy and dignity for example staff showed certain consultation rooms did not have adjustable couches for patients with limited mobility to access and other rooms had very poor sound proofing.
- We found the cancer centre carried out weighing and height measurement in an open area which did not respect individual patient privacy.
- Staff confirmed patients had access to both psychiatric and counselling services as and when required.

Learning from complaints and concerns

- Initial complaints were dealt with by clinic managers in outpatients and diagnostic imaging in an attempt to resolve issues locally. However if this was unsuccessful patients would be referred to the patient and liaison service (PALS).
- We saw PALS posters were clearly displayed and complaint information leaflets were available in each of the areas we visited. However this information was not available in languages other than English.
- We found in radiology the service had provided a notice board for patients to see what had been done in response to concerns and suggestions for improvements raised for example the service had introduced higher chairs for people with limited mobility to use.
- A current trust complaints policy was in place. For the period August 2015 to July 2016 the trust received 553 formal complaints. The numbers of complaints related to outpatients and diagnostic imaging was 203. Of the complaints we reviewed 40 related to staff attitude, 46 related to delayed or cancelled appointments and 54 related to concerns about clinical treatment.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

At the previous inspection in July 2014 we rated well led as good. Following this inspection we have changed the rating to requires improvement because;

- Staff morale varied across different teams. In some areas we found that morale was low and staff felt under pressure because of the workload and lack of capacity to meet the targets.
- At our last inspection the outpatient staff had undergone a service transformation in the 18 months prior to our inspection which had resulted in low morale. At this inspection we found that further reorganisation was ongoing with new middle and senior managers in post.
- The Clinical Investigations Unit (CIU) reported through two different divisional structures which may impact on staff ability to provide clear risk, governance and quality management.
- We found that staff were unclear about the recent divisional changes and were not aware of a local vision for outpatients and imaging services.
- Due to the recent changes to governance systems within the individual divisions and departments, assurance as to the robustness of these structures, including committee membership was limited. We found a lack of representation at relevant safety meetings for the majority of the outpatient departments including ENT, cardio respiratory and dermatology. It was unclear how individual departments and teams were able to participate in discussions related to safety and quality without clear reporting structures and communication systems.
- Staff were unaware of local risks and we found that in only two areas a robust department risk register was in place and being actively managed by the individual team. The lack of clearly identified and managed risks for each individual area within outpatients and diagnostic imaging meant that we were not assured that the service had a full oversight of the governance, quality and risk management of the services. The lack of clarity in reporting structures for individual teams also impacted on the level of assurance within the division in regards to the identification, management and mitigation of risk. For example: ophthalmology services reported under two divisional structures and outpatient physiotherapy services reported under a separate division which may mean a risk identified may not be clearly communicated through the correct division for appropriate action.
- Results of the 2015 NHS Staff survey showed the trust scored worse than the national average for effective team working and organisation and management interest in and action on staff health and wellbeing. The trust scored in line with the national average for the majority of indicators and performed better than average for three indicators related to the levels of

bullying from both staff and patients and staff working extra hours. The trust performed in line with the national average for 23 indicators. It was noted 14 out of the 23 indicators were worse than the previous survey results. Many staff told us they were unaware of any recent patient feedback. The lack of patient engagement and feedback could impact on the ability of the service to learn and improve the quality of service provision.

However;

- We found individual leaders were visible and approachable.
- The Specialist Mobility Rehabilitation centre (SMRC), day treatment centre and diagnostic services were actively managing their own risk registers.
- There was an open and honest culture within the service. In dermatology, diagnostics and SMRC morale was very positive.
- At this inspection we found that the trust had introduced systems to gather the views of patients within outpatients and diagnostic imaging via the NHS Friends and Family test using text systems.
- The introduction in dermatology of a computerised diary enabled the service to plan a block of care in advance to suit the requirements of each patient giving better patient flow.

Vision and strategy for this service

- The trust had a vision and strategy to provide "excellent care with compassion". This was displayed throughout the outpatient and diagnostic departments. Staff said they were aware of the wider trust vision.
- However we found that staff were unclear about the recent divisional changes and were not aware of a local vision for outpatient and imaging services.
- Within the SMRC staff were very clear about the vision to be nationally recognised for their work.

Governance, risk management and quality measurement

- Clinical governance meetings were held monthly in radiology to review incidents, including mortality and morbidity.
- The SMRC held monthly governance meetings which included clinical patient safety and risk reports as well as clinical audit feedback.
- Radiation safety meetings were held to ensure clinical radiation procedures in the trust were undertaken in compliance with ionising and non –ionising radiation legislation. The trust also held Radiation Protection Supervisors meetings which detailed discussion regarding radiation procedures, incidents and protocols.
- Due to the recent changes in governance systems within individual divisions and departments, we found limited assurance in the effectiveness of these structures, including limited committee membership and representation. For example, we reviewed the minutes of the "Anaesthetics and Outpatient (OPD) directorate governance" meeting for the three months prior to our inspection. A patient's safety report was presented at these meetings. We found a lack of representation at this meeting from the majority of the outpatient departments including ENT, cardio respiratory and dermatology. It was unclear how individual departments and teams were able to participate in discussions related to safety and quality without clear structures and communication systems.
- The Clinical Investigations Unit (CIU) reported through two different divisional structures which may impact on staff ability to provide clear risk, governance and quality management.
- The lack of clarity in reporting structures for individual teams also impacted on the level of assurance within the division in regards to the identification, management and mitigation of risk. For example: ophthalmology services reported under two divisional structures and outpatient physiotherapy services reported under a separate division which may mean a risk identified may not be clearly communicated through the correct division for appropriate action.
- We reviewed the trust wide risk register which did include individual department risks. We found that in only two areas SMRC and diagnostic imaging a robust department risk register was in place and being actively managed by the individual team. The lack of clearly identified and managed risks for each individual area within outpatients and diagnostic imaging meant that we were not assured that the service had a full oversight of the governance, quality and risk management of the services.
- A weekly performance meeting was held to manage performance waiting times. Patients waiting over 18 weeks were identified and oversight was provided by clinicians to ensure priority was given to the most

clinically urgent patients. The trust provided a diagnostic and clinical support division safety and quality report for July 2016 which outlined key patients safety and performance indicators including theatre performance data. The cross divisional reporting structures resulted in no overarching quality and performance dashboards being available for all the outpatient and diagnostic services. We raised this with divisional senior managers who confirmed that new governance structures were in place and plans included further devolvement of risk and quality management to individual teams and managers.

- The patient experience group arranged observational visits to outpatient and diagnostic areas, following an agreed checklist including questions for both patients and staff about the quality of the service. The team produced a report and any actions required were then followed up.
- The trust had weekly inspections arranged by nursing teams to review service provision such as cleanliness and patients' safety. We saw examples of the reviews and action plans which had been put in place for example highlighting hand hygiene and improved communication with patients.

Leadership of service

- At our last inspection the outpatient staff had undergone a service transformation in the 18 months prior to our inspection which had resulted in low morale. At this inspection we found that further reorganisation was ongoing with new middle and senior managers in post. A quarter of staff were unclear about the new divisional leadership structure and could not identify either which division they reported under or the names of their divisional leaders.
- Staff felt locally supported however they said that the senior executive team were not always visible but had attended the department recently.
- The staff were very positive about the clinical leads in SMRC and Dermatology and felt well supported.
- The radiology and imaging leadership programme for newly appointed managers had been very well received.

Culture within the service

- In radiology and imaging and pathology all staff spoken to said they felt very supported by their line manager and morale was good.
- Staff felt part of the wider hospital trust despite some departments being based away from the main hospital site.
- There was an open and honest culture across the outpatient and diagnostic imaging services and staff were candid about the challenges they faced. Staff understood the need for openness and transparency and were knowledgeable about their responsibly under the duty of candour regulations.
- Staff morale varied across different teams. In dermatology and SMRC morale was very positive. However in ophthalmology and ENT we found that morale was low and staff felt under pressure because of the pressure of work and lack of capacity to meet the targets. Morale was low within the core therapy services with staff concerned about frozen posts and the ongoing therapy and nursing workforce review.
- In general outpatients we found that staff were committed to trying to work with the trust managers to deliver the services. However we found the "goodwill" of staff was being tested in part due to the increased number of extra clinics in place to meet the demand on the service and further planned changes to staff pay and conditions.

Public engagement

- At our last inspection we told the trust they should ensure it receives feedback from patients within the outpatients departments to monitor and measure quality and identify areas for improvement. At this inspection we found that the trust had introduced systems to gather the views of patients within outpatients and diagnostic imaging via the NHS Friends and Family test using text systems. We found comments cards in the X-ray and ultrasound waiting area. However we only saw patient feedback information on display in dermatology and x-ray. Many staff told us they were unaware of any recent feedback and some staff told us that they thought that the trust no longer collected patient feedback. The lack of patient engagement and feedback could impact on the ability of the service to learn and improve the quality of service provision.
- The majority of people we spoke with were positive about their care but voiced concerns about some delays in receiving their appointment and parking facilities on site.

Outpatients and diagnostic imaging

- The trust had established a patient experience improvement group with non-clinical members to promote greater patient engagement.

Staff engagement

- Results of the 2015 NHS Staff survey showed the trust scored worse than the national average for effective team working and organisation and management interest in and action on staff health and well being. The trust scored in line with the national average for the majority of indicators and performed better than average for three indicators related to the levels of bullying from both staff and patients and staff working extra hours. The trust performed in line with the national average for 23 indicators. However it was noted 14 out of the 23 indicators were worse than the previous survey results.
- Physical and psychological support services were available to staff and staff were aware of how to access these services.
- Staff were recognised for their work by positive feedback and recognition awards known as “Fabulous Feedback Fridays” These were seen as a positive by staff.
Innovation, improvement and sustainability
- The introduction in dermatology of a computerised diary, which colour coded patients by procedure enabled the service to plan a block of 12 week care in advance to suit the requirements of each patient. It also flagged and calculated potential breaches giving better patient flow, enabling comprehensive audit of care provision and treatment outcomes.
- The Specialist Mobility Rehabilitation Service had been internationally recognised for its work with war veterans.
- The SMRC had also been awarded a national customer service award six times.

Outstanding practice and areas for improvement

Outstanding practice

In outpatients and diagnostic imaging services the introduction in dermatology of a computerised diary colour codes patients by procedure enabling the service to plan a block of 12 week care in one go to suit the requirements of each patient. It also flags and calculates potential breaches giving better patient flow, facilitating comprehensive audit of care provision and outcome of treatment.

Critical care had launched the Sleep Improvement in Adult Critical Care Programme. Disturbed sleep in critical care patients is associated with delirium, in which patients become confused, restless and experience hallucinations. This can delay their recovery from critical illness. The trust recognised this and identified the potential disturbances to sleep. To minimise disruption to patients during the night, they offered eye masks and earplugs, dimmed lights, anticipated empty infusion alarms, turned down the volume on medical equipment and phones and encouraged staff to talk away from the bedside. Staff were also reminded to check regularly for signs of delirium. The project and associated resources were shared with neighbouring critical care networks and at national meetings. An initial research study showed that making small changes caused a 50% reduction in patient delirium and significantly improved the quality of sleep experienced by patients. The study had won an initiative award at the National Nursing Times Awards.

Areas for improvement

Action the hospital MUST take to improve

Urgent and Emergency Services

- The service must ensure access to the main entrance paediatric waiting area is limited to reduce the risk of children exiting the area through the automatic doorway.
- The service must ensure intravenous fluids are stored securely and daily checks are completed with actions to address issues identified, completed.
- The service must ensure mandatory training, including safeguarding, compliance reaches and consistently achieves the trust target.
- The service must ensure clinical staff are aware of and adhering to the requirement for senior review of specific patient groups prior to discharge from the ED
- The service must ensure appropriate signage is displayed in areas where close circuit television cameras are used.
- The service must ensure action plans following CEM audits target areas of poor performance and improve practice.
- The service must improve performance, particularly in relation to the department of health four hour target; wait times following a decision to admit, ambulance handovers.
- The service must ensure version control for policies, procedures and guidance is robust and that these are kept up to date and reviewed regularly.
- The service must ensure the department has a dedicated risk register with start dates, timelines, mitigating action and responsible person with review dates included.

Medical Care (including older peoples care)

- The service must ensure that all staff receive appraisals and complete mandatory training to enable them to carry out the duties they are employed to perform.
- The service must ensure that records are kept secure at all times, so that they are only accessed by authorised people.
- The service must ensure procedures in place around medicine management are robust and that policies are followed.
- The service must ensure the risk registers are consistent and demonstrate mitigating actions and review dates.

Surgery

Outstanding practice and areas for improvement

- The service must take appropriate actions to improve staff training compliance in areas such as safeguarding training and life support training.
- The service must take appropriate actions to ensure that patients requiring escalation as part of the national early warning score system (NEWS) are appropriately escalated by staff.
- The service must take appropriate actions to improve compliance against 18 week referral to treatment standards.
- The service must take appropriate actions to reduce the number of cancelled operations and the number of patients whose operations were cancelled and were not treated within the 28 days.

Critical Care

- The service must ensure they mitigate against all risks associated with their noncompliance with the Department of Health Building Note 04-02 for Critical Care Units regarding the specified minimum amount of bed space required to safely locate and utilise required equipment.
- The service must ensure that escalation procedures are followed appropriately across the hospital where patients' National Early Warning Scores (NEWS) are greater than five and the patient may need to be assessed for admittance to the critical care unit.
- The service must ensure that any patients admitted to Ward 2A, who are assessed as Level 2 high dependency patients, receive nursing care at a ratio of 1:2 in accordance with national standards.
- The service must ensure there are actions in place and being implemented to address the audit of compliance against recommendations in relation to critical care outreach services.
- The trust must bring staffing levels of Pharmacists, Dieticians and Physiotherapists on the unit to within the recommended numbers for the size of unit according to GPICS standards.
- The service must take appropriate actions to reduce the number of delayed discharges and therefore mitigate the associated risk.

Maternity and Gynaecology

- The service must ensure midwifery and support staffing levels and skill mix are sufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient.
- The service must take action to ensure that there is a safe system for protecting babies from abduction.
- The service must ensure all necessary staff completes mandatory training, including Level 3 safeguarding training and annual appraisals.
- The service must ensure that the assessment and mitigation of risk and the delivery of safe patient care is in the most appropriate place.
- The service must review the impact of outlier patients on the access and flow within the gynaecology wards.
- The service must complete risk assessments for midwives carrying medical gases in their cars and develop a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.
- The service must ensure that all staff receive medical devices training to ensure all equipment is used in a safe way.

Services for Children and Young People

- The service must ensure that staffing levels in neonatal and children's services are maintained in accordance with national guidelines.
- The service must ensure that all relevant staff having regular contact with children, as defined by intercollegiate guidance, complete level three safeguarding training.
- The service must ensure that indicators for managing the changing condition of ill children are consistently used and responded to appropriately on the children's ward.
- The service must ensure that the isolation room used on the children's ward is free from access to ligature points
- The service must ensure that patient records are kept securely in the children's out patients department.
- The service must ensure that checks on emergency resuscitation equipment, are completed and accurately recorded on the neonatal unit.
- The service must ensure that secure access to the neonatal unit and children's ward is maintained at all times by staff, parents and visitors

Outpatients and diagnostic imaging services

Outstanding practice and areas for improvement

- The service should ensure that clear processes and structures are in place for the management and reviewing of governance, quality and risks.
- The service should review the processes for managing access and flow for outpatient services to ensure patients are not put at risk.
- The service should ensure staff complete mandatory training as per the trust policy.

Action the hospital SHOULD take to improve

Urgent and Emergency Services

- The service should work to embed the forthcoming escalation process to support staff when capacity issues arise.
- The service should have access to information in languages other than English
- The service should improve attendance at monthly ED safeguarding meetings

Medical Care (including older peoples care)

- The service should ensure that patients are discharged as soon as they are fit to do so.
- The service should ensure that patients are not moved ward more than is necessary during their admission and are cared for on a ward suited to meet their needs.
- The service should consider improving the environment of the discharge lounge to maintain patient's privacy and dignity.
- The service should ensure that patients have access to pressure relieving equipment at all times.
- Consider implementing formal procedures for the supervision of staff to enable them to carry out the duties they are employed to perform.

Surgery

- The service should take appropriate actions to maintain safe nurse staffing levels across the surgical wards.
- The service should take appropriate actions to improve the general environment in the theatre areas.
- The service should take appropriate actions to improve staff appraisal completion rates.
- The service should take appropriate actions to improve infection rates following knee replacement surgery.

Critical Care

- The trust should ensure intravenous fluids are stored appropriately and are not accessible to patients or visitors on the critical care unit.
- The trust should make every effort to secure funding to expand the critical care unit in order to bring bed spaces within the recommended guidelines, make the flooring safe and to reduce the level of bed occupancy.
- The Critical Care Governance Team should follow up the request for a review of the risk rating of the lack of a specialist critical care trained pharmacist on a weekend.
- The trust should ensure that all staff in critical care receive mandatory training so that trust mandatory training targets are met.
- The trust should ensure that all staff in critical care (especially nursing staff) receive an annual appraisal, in line with trust targets.
- The service should ensure that action plans arising from audits are kept up to date until complete or actions should be removed.
- The service should ensure that GPICS guidelines for 50% of nursing staff to have undertaken a post qualification course in critical care nursing is achieved as soon as possible.
- The trust should for any mitigating actions that could reduce the number of delayed discharges from critical care.
- The trust should look for ways that Speech and Language therapy (SALT) assessments can be carried out in a more timely manner.

Maternity and Gynaecology

- The service should improve the recording of the review dates and version control of all policies and procedures.
- The service should strengthen the risk registers to support the management of risk.
- The service should improve attendance at governance meetings.
- The service should consider the safe storage of patient's notes on the gynaecology wards.
- The service should consider the safe storage of expressed breast milk on the postnatal ward.
- The service should consider the dignity and privacy of patients within the clinical areas, especially where curtains are used between bed areas and waiting areas that are positioned near procedure rooms.

Outstanding practice and areas for improvement

- The service should continue to monitor consultant labour ward presence with an aim to extending weekday and weekend cover.
- The service should ensure that the capacity within the obstetrics and gynaecology theatres prevent delays in patient procedures.
- The service should continue to ensure that processes for the storage, recording and traceability of fetal pregnancy remains on the gynaecology wards are robust.
- The service should improve staff annual appraisal rates.
- The service should increase staff training uptake for Female Genital Mutilation (FGM) training.
- The service should work to better understand the variation in unplanned home birth rates to ensure safety of patients and babies.

Services for Children and Young People

- The service should use an evidence-based dependency tool to manage appropriate staffing ratios for nursing care on the children's ward.
- The service should appropriately meet the continuing needs of patients who are admitted for child and adolescent mental health services, with adequate support and training for nursing staff where this is required.
- The service should accurately record the completed temperature checks for breastmilk fridges and stores on the neonatal unit.
- The service should maintain appropriate environmental temperatures on the children's ward.
- The service should maintain neonatal guidelines in an up to date and accessible format for staff to use on the neonatal unit.
- The service should that complete and maintain appropriate records for staff supervision and appraisals on children's and neonatal wards
- The service should collect patient feedback responses on the children's ward using the NHS Friends and Family Test

End of Life services

- The service should improve compliance for mandatory training particularly safeguarding, life support and care of the dying education.
- SPC staff appraisal rate should meet the trust target of 85%.
- The service should address the low numbers of registered nurses who were trained in delivery of end of life care, particularly surgical staff.
- The service should create a system for monitoring numbers of staff trained in syringe driver use to assure competency.
- The service should consider they take steps to meet the needs of patients by providing a seven day specialist palliative care service.
- The service should review staffing levels to ensure they are adequate to maintain the excellent results of the donor retrieval team.

Outpatient and diagnostic imaging services

- The service should continue to monitor and review the procedures for caring for vulnerable patients attending for cancer therapy.
- The service should consider improving the environment in the Outpatients department to ensure privacy and dignity is maintained.

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
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **12(2)(a) Assessing the risk to the health and safety of service users of receiving care or treatment.** • The emergency department was routinely missing Department of Health targets in relation to timely care, treatment, admission or discharge. **12(2)(b) Doing all that is reasonably practicable to mitigate any such risks:** • The provider must ensure that the assessment and mitigation of risk and the delivery of safe patient care is in the most appropriate place. • The provider must take action to ensure that there is a safe system for protecting babies from abduction. • The main entrance to the paediatric emergency department waiting area had doors which opened automatically, allowing children to exit freely onto a main thoroughfare. • Staff must follow plans and pathways. • Medical staff were not all aware of the need for senior clinical review of certain patients prior to discharge. • Nursing staff did not always follow indicators for managing the changing condition of ill children appropriately • A significant proportion of surgical patients waited longer than the 18 week referral to treatment wait time standard. • A significant proportion of surgical patients whose operations were cancelled were not treated within the 28 days. • Patients that required escalation as part of the national early warning score system (NEWS) were not always appropriately escalated by staff. • Appropriate actions to reduce the number of delayed discharges from critical care and therefore mitigate the associated risk, were not always taken.

This section is primarily information for the provider

Requirement notices

- The impact of outlier patients on the access and flow within the gynaecology wards was significant.
- The processes for managing access and flow for outpatient services to ensure patients are not put at risk required stregthening.

12 (2) (d) ensuring that premises used by the service provider are safe for their intended purpose and are used in a safe way

- Secure access to the children's ward was not consistently observed by parents and monitored by staff at all times.
- A potential ligature point was observed in the ensuite bathroom facility for the isolation room used on the children's ward.
- Mitigation against all risks associated with their noncompliance with the Department of Health Building Note 04-02 for Critical Care Units regarding the specified minimum amount of bed space required to safely locate and utilise required equipment was not sufficient.

12(2)(e) Ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way:

- The hospital must ensure that all staff receives medical devices training to ensure all equipment is used in a safe way.
- Checks of emergency resuscitation equipment on the neonatal unit were not accurately recorded at all times

12(2)(g): the proper and safe management of medicines:

- Staff must follow policies and procedures about managing medicines.
- Systems in place for medicine management across medical services were not always robust or followed, which put patients at risk.
- In the emergency medical decisions unit, intravenous fluids were not being stored securely, fridge temperatures were not checked every day and actions to address temperature issues were not completed.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Maternity and midwifery services

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17(1) Good governance

17(2)(c): Records must be kept secure at all times.

- Records were not always kept secure across medical wards and therefore were accessible to members of the public.
- Patient records were left on shelves overnight in the children's outpatient department, with potential for public access when the department was unsupervised

17(2)(b): assess, monitor and mitigate risks: Providers must have systems and processes that enable them to identify and assess risk to the health, safety and/or welfare of people who use the service.

- Across medical, urgent and emergency services inconsistencies in risk registers did not give assurance that they were managed effectively or within a timely manner.
- OPD processes and structures for the management and reviewing of governance, quality and risks were not clear or robust.

17(2)(e): Providers must seek and act on feedback for the purpose of continually evaluating and improving such service.

- Action following poor results from College of Emergency Medicine audits was insufficient.
- Actions to address the audit of compliance against recommendations in relation to critical care outreach services were not in place or implemented.

17(2)(a): Information must be up to date, accurate and properly analysed and reviewed.

- Guidelines, policies and procedures used in the emergency department, had review dates which had expired.

17(2)(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others:

This section is primarily information for the provider

Requirement notices

- There was no risk assessments for midwives carrying medical gases in their cars or a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **18 (1) Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs.** • Nurse staffing did not meet national guidelines for caring of the neonatal and children's wards • Midwifery and support staffing levels and skill mix were insufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient. • Patients admitted to Ward 2A, who are assessed as Level 2 high dependency patients, did not always receive nursing care at a ratio of 1:2 in accordance with national standards. • Staffing levels of Pharmacists, Dieticians and Physiotherapists on the critical care unit were not within the recommended numbers for the size of unit according to GPICS standards. **18 (2)(a) - Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.** • The proportion of staff across the surgical services that had completed adult and children's safeguarding training and the proportion of staff that had completed adult and paediatric life support training was below expected levels. • Mandatory training compliance in a number of service areas was low and did not reach trust compliance targets.

This section is primarily information for the provider

Requirement notices

- Not all required staff had completed mandatory training, including Level 3 safeguarding training (as set out in intercollegiate guidance) and/or received annual appraisals.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **15(1)(b): Any surveillance should be operated in line with current guidance** **The emergency department was not displaying appropriate signage to indicate that close circuit television was in use.**